



CGI Technologies and Solutions
Inc.
11325 Random Hills Rd
Fairfax, VA 22030
phone: (703) 267-8626
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www.cgi.com

September 26, 2011

JoAnn Cowger
Iowa Medicaid Enterprise
100 Army Post Road Des Moines, IA 50315
Phone: (515) 256-4646
jcowger@dhs.state.ia.us

Subject: Request for Proposals for a Qualified Contractor(s) to Assist in the Development and Implementation of Iowa's Electronic Health Records Medicaid Incentive Payment Administration Tool.

Dear Ms. Cowger:

CGI Technologies and Solutions Inc. (CGI) is pleased to present the enclosed response to the Iowa Department of Human Services' Request for Proposals (RFP) for a Qualified Contractor(s) to assist in the Development and Implementation of Iowa's Electronic Health Records Medicaid Incentive Payment Administration Tool.

The State of Iowa is undertaking an ambitious project to implement a state-of-the-art Medicaid Electronic Health Record (EHR) Incentive Program Tool as a vehicle to encourage the State's health care provider network to adopt, implement and utilize EHR technologies to improve the quality and efficiency of healthcare services to the visitors and residents of the State. It is clear that Iowa understands the ultimate goal of the program extends far beyond provider portals and interfaces. The long term goal is to deliver real value to its residents in the form of better health outcomes, superior quality of care, improved patient safety and increased savings. To achieve these goals, Iowa will be best served by engaging with a partner experienced in the public sector health industry, who has expert knowledge of Health Reform, and direct experience with the Medicaid EHR Incentive Program. It is for these reasons that CGI is uniquely positioned to partner with Iowa on the Medicaid EHR Incentive Program project.

CGI is proud to offer our knowledge, experience and successful track record of partnership to the State of Iowa.

In CGI, you will find a partner with:

- ***The experience.*** CGI brings industry-leading subject matter expertise of public sector Medicaid and Health Reform with direct experience with the Medicaid EHR Incentive Program at both the state and federal levels. We are the only vendor associated with a CMS Group 1 State who led the development and implementation of a solution and met the January 3, 2011 deadline. We also can claim to be the first vendor to stand-up and



operate an end-to-end business and technical services support infrastructure for a Medicaid EHR Incentive Program. As a demonstration of our commitment to the success of the Iowa implementation, we have proposed many of our core Health Reform experts who have been dedicated to this program since its inception.

- ***The solution.*** CGI brings an existing state-of-the-art Medicaid EHR Incentive Program solution, Medicaid Incentive360™ (Medicaid Incentive360) that will be leveraged as a flexible and scalable platform to meet Iowa's requirements. This system is already supporting the administration and incentive payments for the State of Texas and State of Ohio and meets the rules and guidance issued to date from CMS for the program. As the baseline software designed and developed by CGI is public domain, CGI is uniquely positioned to provide it to Iowa at no cost. Using Medicaid Incentive360 as a platform brings multiple benefits to the State: reduces the time to implement, reduces the project's risk, and reduces the project cost while still affording Iowa the flexibility to meet the State's unique requirements through configuration.
- ***The track record.*** CGI has proven experience designing, developing and implementing on-time and on-budget solutions, including Medicaid EHR Incentive Programs, with a strong focus on customer satisfaction. At CGI, we take a long-term view for each engagement regardless of size, forging and growing partnerships with our three main stakeholders—clients, members (employees) and shareholders. This view is supported by our financial strength which enables us to continuously invest and improve services and business solutions to the benefit of our clients. In addition, CGI is a leading healthcare systems integrator. We bring significant experience in the healthcare industry, supporting healthcare solution initiatives for providers, payers and governments.
- ***The commitment to Iowa.*** CGI has been an IT partner with the State of Iowa for over 20 years and has partnered with the State for mission critical systems such as the I/3 financial administrative system and the computer-assisted collection system (CACS-G) for the management of tax revenue collections. Importantly, these have allowed CGI to form partnerships with the respective agencies that have stood the test of time. Iowa's EHR Medicaid Incentive Program is another endeavor where an IT vendor must be selected who can be trusted to deliver on the promise of technology through a trusted partnership alliance. CGI has a commitment to Iowa and has demonstrated our ability to succeed in delivering technology to derive operational improvements for the State of Iowa.

CGI offers our solution both as a Software-as-a-Service (SaaS) and as a solution hosted in your environment and, as such, we have submitted two proposals for Iowa's consideration. This proposal highlights our Iowa-Hosted offering.

Founded in 1976, CGI is one of the largest independent information technology and business process services firms in the world. CGI provides end-to-end IT and business process services to clients worldwide from offices in the United States, Canada, Europe and Asia Pacific, as well as



from centers of excellence in North America, Europe, and India. Rooted in quality processes and frameworks, our goal is to satisfy client objectives, serving as an accountable, flexible and objective partner.

With annualized revenue of \$4.5B and a backlog of \$13.6B, CGI and its affiliated companies employ approximately 31,000 professionals and count over 100 federal agencies and over 190 U.S. state and local governments as our clients. CGI shares are listed on the TSX (GIB.A) and the NYSE (GIB) and are included in the S&P/TSX Composite Index and the S&P/TSX Capped Information Technology and MidCap Indices.

Public sector solutions and services have been a cornerstone of CGI since the very beginning. We currently have 8,500+ professional services employees in the U.S. focused specifically on the public sector in areas such as health and human services, tax and revenue collections, spend management, document and records management, public safety and custom solution design/development. We provide government clients with a full range of IT and business process services that include enterprise architecture, technology planning, application implementation and integration, and custom solutions design and delivery.

CGI is a Delaware corporation, with its principal place of business at 11325 Random Hills Road, Fairfax, Virginia 22030. Our Federal Tax ID is # 54-0856778. For more detailed information about CGI, we invite you to visit our website at <http://www.cgi.com>.

Holli Ploog, Vice-President, Global Enterprise Markets, is authorized to legally bind CGI to the provisions of the RFP. If you have questions or require clarification on the information that has been provided, please contact Ms. Ploog at:

CGI Technologies and Solutions Inc.
11325 Random Hills Rd
Fairfax, VA 22030
Phone: (703) 267-8626
Fax: (703) 638-0727

On behalf of our team, we would like to thank you for the opportunity to serve the State of Iowa.

Sincerely,

Holli Ploog
Vice-President, Global Enterprise Markets



1 BID PROPOSAL SECURITY

The bidder shall submit a bid bond, a certified or cashier's check, or an irrevocable letter of credit in favor of or made payable to the Agency in the amount of ten percent of the proposal costs listed in the cost proposal. The bid proposal security must be valid beginning on the Bid Proposal due date for 90 days. The bidder understands that if the bidder elects to use a bond, a surety licensed to do business in Iowa must issue the bond on a form acceptable to the Agency. The bidder understands that the bid proposal security shall be forfeited if the bidder is chosen to receive the contract and withdraws its Bid Proposal after the Agency issues a Notice of Intent to Award, does not honor the terms offered in its Bid Proposal, or does not negotiate contract terms in good faith. The bidder further understands that the bid proposal security submitted by bidders will be returned, if not forfeited for reasons stated above, when the Bid Proposals expire, are rejected, or the Agency enters into a contract with the successful bidder, whichever is earliest.

CGI has secured a Bid Bond in the amount of \$5,000. Please see the following page of this section.



AIA Document A310
Bid Bond

Bond No. MNR413620-102

KNOW ALL MEN BY THESE PRESENTS, that we CGI TECHNOLOGIES AND SOLUTION INC., 11325 Random Hills Road, Fairfax, VA 22030, as Principal, hereinafter called the Principal, and

WESTCHESTER FIRE INSURANCE COMPANY, 436 Walnut Street, Philadelphia, PA 19106 a corporation duly organized under the laws of Commonwealth of Pennsylvania as Surety, hereinafter called the Surety, are held and firmly bound unto

IOWA DEPARTMENT OF HUMAN SERVICES, 100 Army Post Road, Des Moines, IA 50315 as Obligee, hereinafter called the Obligee, in the sum of five thousand-----00/100 (\$5,000.00), for the payment of which sum well and truly to be made, the said Principal and the said Surety, bind ourselves, our heirs, executors, administrators, successors and assigns, jointly and severally, firmly by these presents.

WHEREAS, the Principal has submitted a bid for Electronic Health Records Medicaid Incentive Payment Administration Tool – MED-012-003.

NOW, THEREFORE, if the Obligee shall accept the bid of the Principal and the Principal shall enter into a Contract with the Obligee in accordance with the terms of such bid, and give such bond or bonds as may be specified in the bidding or Contract Documents with good and sufficient surety for the faithful performance of such Contract and for the prompt payment of labor and material furnished in the prosecution thereof, or in the event of the failure of the Principal to enter such Contract and give such bond or bonds, if the Principal shall pay to the Obligee the difference not to exceed the penalty hereof between the amount specified in said bid and such larger amount for which the Obligee may in good faith contract with another party to perform the Work covered by said bid, then this obligation shall be null and void, otherwise to remain in full force and effect.

Signed and sealed this 16th day of September 2011
the Presence of

CGI TECHNOLOGIES AND SOLUTIONS INC.

Donna Colvin
(Witness)

Helli Plooy
(Principal) (Seal)
VP
(Title)

WESTCHESTER FIRE INSURANCE COMPANY

Carole Thiboutot
(Witness) Carole Thiboutot

Giuseppina Sauro
(Surety) (Seal)
Giuseppina Sauro, attorney-in-fact
(Title)

Power of Attorney

WESTCHESTER FIRE INSURANCE COMPANY

Know all men by these presents: That WESTCHESTER FIRE INSURANCE COMPANY, a corporation of the Commonwealth of Pennsylvania pursuant to the following Resolution, adopted by the Board of Directors of the said Company on December 11, 2006, to wit:

"RESOLVED, that the following authorizations relate to the execution, for and on behalf of the Company, of bonds, undertakings, recognizances, contracts and other written commitments of the Company entered into the ordinary course of business (each a "Written Commitment"):

- (1) Each of the Chairman, the President and the Vice Presidents of the Company is hereby authorized to execute any Written Commitment for and on behalf of the Company, under the seal of the Company or otherwise.
- (2) Each duly appointed attorney-in-fact of the Company is hereby authorized to execute any Written Commitment for and on behalf of the Company, under the seal of the Company or otherwise, to the extent that such action is authorized by the grant of powers provided for in such persons written appointment as such attorney-in-fact.
- (3) Each of the Chairman, the President and the Vice Presidents of the Company is hereby authorized, for and on behalf of the Company, to appoint in writing any person the attorney-in-fact of the Company with full power and authority to execute, for and on behalf of the Company, under the seal of the Company or otherwise, such Written Commitments of the Company as may be specified in such written appointment, which specification may be by general type or class of Written Commitments or by specification of one or more particular Written Commitments.
- (4) Each of the Chairman, the President and Vice Presidents of the Company is hereby authorized, for and on behalf of the Company, to delegate in writing any other officer of the Company the authority to execute, for and on behalf of the Company, under the Company's seal or otherwise, such Written Commitments of the Company as are specified in such written delegation, which specification may be by general type or class of Written Commitments or by specification of one or more particular Written Commitments.
- (5) The signature of any officer or other person executing any Written Commitment or appointment or delegation pursuant to this Resolution, and the seal of the Company, may be affixed by facsimile on such Written Commitment or written appointment or delegation.

FURTHER RESOLVED, that the foregoing Resolution shall not be deemed to be an exclusive statement of the powers and authority of officers, employees and other persons to act for and on behalf of the Company, and such Resolution shall not limit or otherwise affect the exercise of any such power or authority otherwise validly granted or vested.

Does hereby nominate, constitute and appoint Carole Thiboutot, Giuseppina Sauro, all of the City of MONTREAL, Quebec (Province De Quebec), each individually if there be more than one named, its true and lawful attorney-in-fact, to make, execute, seal and deliver on its behalf, and as its act and deed any and all bonds, undertakings, recognizances, contracts and other writings in the nature thereof in penalties not exceeding Ten million dollars & zero cents (\$10,000,000.00) and the execution of such writings in pursuance of these presents shall be as binding upon said Company, as fully and amply as if they had been duly executed and acknowledged by the regularly elected officers of the Company at its principal office.

IN WITNESS WHEREOF, the said Stephen M. Haney, Vice-President, has hereunto subscribed his name and affixed the Corporate seal of the said WESTCHESTER FIRE INSURANCE COMPANY this 22 day of February 2011.

WESTCHESTER FIRE INSURANCE COMPANY

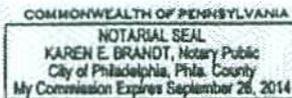


Stephen M. Haney
Stephen M. Haney, Vice President

COMMONWEALTH OF PENNSYLVANIA
COUNTY OF PHILADELPHIA ss.

On this 22 day of February, AD. 2011 before me, a Notary Public of the Commonwealth of Pennsylvania in and for the County of Philadelphia came Stephen M. Haney, Vice-President of the WESTCHESTER FIRE INSURANCE COMPANY to me personally known to be the individual and officer who executed the preceding instrument, and he acknowledged that he executed the same, and that the seal affixed to the preceding instrument is the corporate seal of said Company; that the said corporate seal and his signature were duly affixed by the authority and direction of the said corporation, and that Resolution, adopted by the Board of Directors of said Company, referred to in the preceding instrument, is now in force.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my official seal at the City of Philadelphia the day and year first above written.



Karen E. Brandt
Notary Public

I, the undersigned Assistant Secretary of the WESTCHESTER FIRE INSURANCE COMPANY, do hereby certify that the original POWER OF ATTORNEY, of which the foregoing is a substantially true and correct copy, is in full force and effect.

In witness whereof, I have hereunto subscribed my name as Assistant Secretary, and affixed the corporate seal of the Corporation, this 16th day of September, 2011.



William L. Kelly
William L. Kelly, Assistant Secretary

THIS POWER OF ATTORNEY MAY NOT BE USED TO EXECUTE ANY BOND WITH AN INCEPTION DATE AFTER February 22, 2013.

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- Laid lines on the back of document should be in alignment or the document is not authentic - watch for cut and paste.
- Microprinting - under magnification, the inside border on the front of this document should read: "Standard Register Standardized Security".
- Thermo-chromic Ink - Standard Register mark on back of document fades from blue to clear when heat is applied.
- An Artificial Watermark is present and is viewable at an angle.
- Security void pattern on front if copied.



2 TABLE OF CONTENTS

1	Transmittal Letter	1
1	Bid Proposal Letter	4
2	Table of Contents	6
3	RFP Forms	7
	Release of Information Form	8
	Primary Bidder Detail & Certification Form.....	9
4	Approach to Meeting Deliverables	22
4.1	Deliverables.....	22
4.2	Performance Measures	94
4.3	Contract Payment Methodology.....	95
4.4	Draft Documents.....	95
	Work Plan	96
	Training Plan	97
	Project Timeline	98
	Screen Shots	99
	Sample Reports.....	100
5	Bidder’s Background	102
5.1	Experience	102
5.2	Similar Services.....	112
5.3	Other Relevant Experience.....	119
5.4	Letters of Reference	132
5.5	Subcontractor Management.....	132
5.6	Personnel	132
5.7	Financial Statements	138
5.8	Termination, Litigation, and Investigation.....	139
	Letters of Reference	141
	Resumes Error! Bookmark not defined.	
	Financial Statements	143



2 RFP FORMS

Please find the following completed forms in the remaining pages of this tab:

- ▶ Release of Information Form
- ▶ Primary Bidder Detail & Certification Form

CGI does not intend to use subcontractors for this engagement. Therefore, we have not included a Subcontractor Disclosure Form.

Attachment A: Release of Information

(Return this completed form behind Tab 3 of the Bid Proposal.)

CGI Technologies and Solutions Inc. (name of bidder) hereby authorizes any person or entity, public or private, having any information concerning the bidder’s background, including but not limited to its performance history regarding its prior rendering of services similar to those detailed in this RFP, to release such information to the Agency.

The bidder acknowledges that it may not agree with the information and opinions given by such person or entity in response to a reference request. The bidder acknowledges that the information and opinions given by such person or entity may hurt its chances to receive contract awards from the Agency or may otherwise hurt its reputation or operations. The bidder is willing to take that risk. The bidder agrees to release all persons, entities, the Agency, and the State of Iowa from any liability whatsoever that may be incurred in releasing this information or using this information.

CGI Technologies and Solutions, Inc.
Printed Name of Bidder Organization

Signature of Authorized Representative

Date

Holli Ploog
Printed Name

Attachment B: Primary Bidder Detail Form & Certification

(Return this completed form behind Tab 3 of the Proposal. If a section does not apply, label it “not applicable”.)

Primary Contact Information (individual who can address issues re: this Bid Proposal)	
Name:	Holli Ploog
Address:	11325 Random Hills Rd Fairfax, VA 22030
Tel:	(703) 267-8626
Fax:	(703) 638-0727
e-mail:	holli.ploog @cgi.com

Primary Bidder Detail	
Business Legal Name (“Bidder”):	CGI Technologies and Solutions Inc.
“Doing Business As” names, assumed names, or other operating names:	N/A
Parent Corporation, if any:	CGI Group Inc.
Form of Business Entity (i.e., corp., partnership, LLC, etc.):	Public Corporation
State of Incorporation/organization:	Delaware
Primary Address:	11325 Random Hills Road Fairfax, VA 22030
Tel:	703-267-8000
Fax:	703-267-5111
Local Address (if any):	
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	CGI Phoenix Data Center 10007 South 51st Street Phoenix, AZ 85044
Number of Employees:	31,000+
Number of Years in Business:	35
Primary Focus of Business:	IT Consulting and Business Process Services
Federal Tax ID:	# 54-0856778
Bidder’s Accounting Firm:	Ernst and Young
If Bidder is currently registered to do business in Iowa, provide the Date of Registration:	4/7/1995
Do you plan on using subcontractors if awarded this Contract? {If “YES,” submit a Subcontractor Disclosure Form for each proposed subcontractor.}	NO

Request for Confidential Treatment (See Section 3.1)		
Location in Bid (tab/page)	Statutory Basis for Confidentiality	Description/Explanation

None		
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Exceptions to RFP/Contract Language (See Section 3.1) – CGI’s proposed additions and replacement are denoted with underscoring. Simple proposed deletions are denoted with strike-throughs.

CGI has used this table to document its concerns regarding the contract terms and conditions of the RFP. These concerns should be regarded as important discussion points for negotiation of the final contract rather than as line-in-the-sand exceptions. We are confident that, in this case as in the past, CGI and the State will readily reach agreement through negotiation on a satisfactory contractual framework for this important project.

CGI believes that its concerns reflect a consistent and simple reasoning process. They are motivated in each case by the goal of appropriately balancing the risks and rewards of the parties in a manner consistent with contracting practices in the state and local government market for similar projects. We acknowledge that there is room for debate on that point, and we believe, again, that debate during negotiation will yield agreement on a robust contract. Other reasons as applicable are specified in the table.

Finally, CGI believes that the cost impact of individual exceptions and proposed additions to the contract terms and conditions specified in the RFP cannot be stated for individual terms. To be accurate, an evaluation of cost impact of such changes must be made holistically in consideration of the overall risk profile of the contract.

RFP Section and Page	Language to Which Bidder Takes Exception	Explanation and Proposed Replacement Language:	Cost Savings to the Agency if the Proposed Replacement Language is Accepted
Sample Contract, Contract Declarations and Execution, page 29	See next column.	Proposed addition: “Contract Warranty Period (hereafter “Warranty Period”): <u>The Warranty Period for each Deliverable and Service, as applicable, shall begin on date the Deliverable is accepted or the Service is completed in accordance with the Contract and shall conclude on [date to be determined].</u> <u>Deficiencies discovered post-Acceptance shall be addressed through warranty and maintenance.</u> ” Reason: see note above.	See note above.
Sample Contract, Section 1.3.3.2, page 30	See next column.	Proposed addition: “... As part of the review(s), the Agency may <u>on reasonable advance notice</u> require the Contractor to provide additional data....” Reason: see note above.	See note above.
Sample Contract, Section 1.3.3.3, page 30	See next column.	Proposed correction and addition: “...The Contract Owner <u>Manager</u> has final authority to approve problem-resolution activities, <u>which approval shall not be unreasonably delayed or withheld.</u> ” Reason: see note above.	See note above.
Sample Contract, Section	See next column.	Proposed addition to end of provision: “ <u>If the Agency does not pay an invoice within 60 calendar days,</u> <u>Contractor may add an interest charge of one percent</u> ”	See note above.

1.3.4.2, page 31		<u>(1%) per month on the unpaid amount of the invoice.”</u> Reason: see note above.	
Sample Contract, Section 2.1, Definition of <i>Acceptance</i> , page 33	See next column.	Proposed addition: “ <u>For purposes of this and other definitions concerning Deliverables Acceptance, satisfy or meet shall be construed to mean satisfy or meet applicable criteria or specifications in all material respects.</u> ” Reason: see note above.	See note above.
Section 2.1, Definition of <i>Acceptance Criteria</i> , page 33	See next column.	Proposed addition to the end of the definition: “ <u>CGI will work with the Agency to develop an effective and reasonable Acceptance plan (“Acceptance Plan”) based on Acceptance Criteria that are objective, measurable, and designed to determine material compliance with applicable Specifications; include adequate time periods for review and acceptance and for correction or re-performance; provide that use of Deliverables used in production without Acceptance or Agency’s failure to give timely notice of Deficiencies shall be deemed Acceptance; and specify that Deficiencies discovered post-Acceptance shall be addressed through warranty and maintenance support.</u> ” Reason: see note above.	See note above.
Sample Contract, Section 2.1, Definition of <i>Deficiency</i> , page 33	See next column.	Proposed addition: “ <u>Deficiency means a material reproducible defect, flaw ...</u> ” Reason: see note above.	See note above.
Sample Contract, Section 2.1, Definition of <i>Deliverable</i> , page 33	See next column.	Proposed addition: “ <u>Deliverables subject to Acceptance Testing will be expressly identified in the Contract.</u> ” Reason: see note above.	See note above.
Sample Contract, Section 2.1, Definition of <i>Force Majeure</i> , page 33	See next column.	Proposed addition: “ <u>... incapable of being avoided by the affected party in a commercially reasonable manner.</u> ” Reason: see note above.	See note above.
Sample Contract, Section 2.5.1, page 34	See next column.	Proposed addition to the beginning of the provision: “ <u>For purposes of this Section 2.5.1, time periods for cure of contract breaches shall be as established pursuant to Section 1.3.3.3 of the Special Terms.</u> ” Reason: see note above.	See note above.
Sample Contract, Section 2.5.1.1, page 34	See next column.	Proposed addition: “ <u>The Contractor knowingly or negligently furnished any statement....</u> ” Reason: see note above.	See note above.

Sample Contract, Section 2.5.1.7, page 35	See next column.	Proposed addition: “The Agency determines or <u>reasonably believes</u>” Reason: see note above.	See note above.
Sample Contract, Section 2.5.5, page 36	See next column.	Proposed addition: “...for which the Agency is obligated to pay pursuant to this Contract, <u>including in the case of a termination pursuant to Section 2.5.2 amounts reflecting satisfactory work in progress on as-yet unaccepted Deliverables and Services as reasonably demonstrated by Contractor....</u> ” Reason: see note above.	See note above.
Sample Contract 2.7, page 37	See next column.	Proposed additions: <u>(i) procedural terms requiring State to give prompt notice of any claims and to assist Contractor in defense as requested at Contractor’s expense; (ii) relieving Contractor of liability for infringement claims resulting from (i) modifications made to the item in question by anyone other than Contractor and its subcontractors working at Contractor’s direction; (ii) the combination, operation or use of the item with other items Contractor did not supply; (iii) Agency’s failure to use any new or corrected versions of the item made available by Contractor; or (iv) Contractor’s adherence to Agency’s specifications or instructions..</u> Reason: see note above.	See note above.
Sample Contract, Section 2.7.1, page 37	See next column.	Proposed additions: “The Contractor agrees to indemnify and hold harmless <u>and defend</u> the State ... including but not limited to any <u>third party</u> claims” Reason: see note above.	See note above.
Sample Contract, Section 2.7.1.1, page 37	See next column.	Proposed deletion: Section 2.7.1.1 in its entirety. Reason: see note above.	See note above.
Sample Contract, Section 2.7.1.3, page 37	See next column.	Proposed deletion: Section 2.7.1.3 in its entirety. Reason: see note above.	See note above.
Sample Contract, Section 2.7.2, page 37	See next column.	Proposed deletion: “The Contractor’s duties and obligations under this section shall survive the expiration or termination of this Contract and shall apply to all acts or omissions taken or made in connection with the performance of this Contract regardless of the date any potential claim is made or discovered by the Agency or any other Indemnified Party. ” Reason: see note above.	See note above.
RFP Section 1.4, Insurance Coverage	See next column.	Professional liability coverage should be per claim. Reason: This is CGI’s existing coverage.	See note above.

MED-012-003 Electronic Health Records Medicaid Incentive Payment Administration Tool

Requirements, page 31			
Sample Contract, Section 2.8.1.1, page 37	See next column.	Proposed addition: “Be occurrence based <u>where applicable</u> and” Reason: This is CGI’s existing coverage.	See note above.
Sample Contract, Section 2.8.1.2, page 37	See next column.	Proposed addition: “Name the State of Iowa and the Agency as additional insureds or loss payees on the policies <u>where applicable</u> for” Reason: This is CGI’s existing coverage.	See note above.
Sample Contract, Section 2.8.1.3, page 38	See next column.	Proposed addition: “...with the exception of <u>Workers’ Compensation and Professional Liability.</u> ” Reason: This is CGI’s existing coverage.	See note above.
Sample Contract, Section 2.10.1, page 38	See next column.	Proposed addition: <p>“The Contractor agrees that the State and Agency shall become the sole and exclusive owners of all Deliverables <u>that are originally created for the Agency pursuant to this Contract (“Original Deliverables”). Deliverables that are in the public domain or owned by Contractor or a third party will be made available to the Agency pursuant to the license terms of this Agreement. Deliverables that are services in the nature of Software as a Service (“SAAS”), will be made available pursuant to a separate SAAS Agreement.</u> The Contractor hereby irrevocably assigns, transfers and conveys to the State and the Agency all right, title and interest in and to all <u>Original Deliverables</u> and all intellectual property rights and proprietary rights arising out of, embodied in, or related to such <u>Original Deliverables</u>, including copyrights, patents, trademarks, trade secrets, trade dress, mask work, utility design, derivative works, and all other rights and interests therein or related thereto. The Contractor represents and warrants that the State and the Agency shall acquire good and clear title to all <u>Original Deliverables</u>, free from any claims, liens, security interests, encumbrances, intellectual property rights, proprietary rights, or other rights or interests of the Contractor or of any third party, including any employee, agent, contractor, subcontractor, subsidiary, or affiliate of the Contractor. The Contractor (and Contractor’s employees, agents, contractors, subcontractors, subsidiaries and affiliates) shall not retain any property interests or other rights in and to the <u>Original Deliverables</u> and shall not use any <u>Original Deliverables</u>, in whole or in part, for any purpose, without the prior written consent of the Agency and the payment of such royalties or other</p>	See note above.

		<p>compensation as the Agency deems appropriate. Unless otherwise requested by the Agency, upon completion or termination of this Contract, the Contractor will immediately turn over to the Agency all <u>paid-for Original Deliverables</u> not previously delivered to the Agency; <u>provide, however that Contractor shall be allowed to retain one copy</u> and no copies thereof shall be retained by the Contractor or its employees, agents, subcontractors, or affiliates, without the prior written consent of Agency for archival purposes.</p> <p>Reason: CGI may propose as Deliverables as defined in Section 2.1 certain intellectual property in the public domain and/or owned by third parties, as well as services in the form of SAAS.</p>	
Sample Contract, Section 2.10.2, page 38	See next column.	<p>Proposed addition: "...agrees not to challenge the State's rights in and to the <u>Original Deliverables</u>."</p> <p>Reason: CGI may propose as Deliverables as defined in Section 2.1 certain intellectual property in the public domain and or owned by third parties, as well as services in the form of SAAS.</p>	See note above.
Sample Contract, Section 2.10.3, page 39	See next column.	<p>Proposed addition: "At the Agency's request, the Contractor will execute and deliver such instruments and take such other action as may be requested by the Agency to establish, perfect, or protect the State's rights in and to the <u>Original Deliverables</u> and to carry out the assignments, transfers and conveyances set forth in Section 2.10, <i>Intellectual Property</i>."</p> <p>Reason: CGI may propose as Deliverables as defined in Section 2.1 certain intellectual property in the public domain and or owned by third parties, as well as services in the form of SAAS.</p>	See note above.
Sample Contract, Section 2.11, page 39		<p>Proposed addition: "<u>THE WARRANTIES CONTAINED IN THIS SECTION 2.11 ARE IN LIEU OF ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, INCLUDING, BUT NOT LIMITED TO, ANY IMPLIED WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, INTEGRATION, PERFORMANCE AND ACCURACY AND ANY IMPLIED WARRANTIES ARISING FROM STATUTE, COURSE OF DEALING, COURSE OF PERFORMANCE OR USAGE OF TRADE.</u>"</p> <p>Reason: see note above.</p>	See note above.
Sample Contract, Section 2.11.1, page 39	See next column.	<p>CGI proposes the following deletion: Construction of Warranties Expressed in this Contract with Warranties Implied by Law. Warranties made by the Contractor in this Contract, whether: (1) this Contract specifically denominates the Contractor's promise as a warranty; or (2) the warranty is created by the Contractor's affirmation or promise, by a description of the Deliverables to be provided, or by provision of</p>	See note above.

		<p>samples to the Agency, shall not be construed as limiting or negating any warranty provided by law, including without limitation, warranties that arise through the course of dealing or usage of trade. The warranties expressed in this Contract are intended to modify the warranties implied by law only to the extent that they expand the warranties applicable to the Deliverables provided by the Contractor. With the exception of Subsection 2.11.3, the provisions of this section apply during the Warranty Period as defined in the Contract Declarations and Execution Section.</p> <p>Reason: see note above.</p>	
<p>Sample Contract, Section 2.11.3.2, page 39</p>	<p>See next column.</p>	<p>Proposed deletions and additions: The Agency’s use of, and exercise of any rights with respect to, the Deliverables <u>in unaltered form</u> (and all intellectual property rights and proprietary rights arising out of, <u>or</u> embodied in, or related to such Deliverables), do not and will not, under any circumstances, misappropriate a trade secret or infringe upon or violate any copyright, patent, trademark, trade dress or other intellectual property right, <u>or</u> proprietary right or personal right of any third party. The Contractor further represents and warrants there is no <u>known</u> pending or threatened claim, litigation, or action that is based on a claim of infringement or violation of an intellectual property right, <u>or</u> proprietary right or personal right or misappropriation of a trade secret related to the Deliverables. The Contractor shall inform the Agency in writing <u>immediately promptly</u> upon becoming aware of any actual, potential, or threatened claim of or cause of action for infringement or violation of an intellectual property right, <u>or</u> proprietary right, or personal right or misappropriation of a trade secret. If such a claim or cause of action arises or is likely to arise, then the Contractor shall, at the Agency’s request and at the Contractor’s sole expense <u>and option</u>:</p> <ul style="list-style-type: none"> • Procure for the Agency the right or license to continue to use the Deliverable at issue; • Replace such Deliverable with a functionally equivalent or superior Deliverable free of any such infringement, violation, or misappropriation; • Modify or replace the affected portion of the Deliverable with a functionally equivalent or superior Deliverable free of any such infringement, violation, or misappropriation; or • Accept the return of the Deliverable at issue and refund to the Agency all fees, charges, and any other amounts paid by the Agency with respect to such Deliverable <u>subject to a reasonable discount reflecting prior use of the Deliverable by the Agency.</u> In 	<p>See note above.</p>

		<p>addition, the Contractor agrees to indemnify, defend, protect, and hold harmless the State and its officers, directors, employees, officials, and agents as provided in the Indemnification Section of this Contract, including for any breach of the representations and warranties made by the Contractor in this section. <u>Contractor is not responsible for any claimed breaches of the foregoing warranties caused by: (i) modifications made to the item in question by anyone other than Contractor and its subcontractors working at Contractor’s direction; (ii) the combination, operation or use of the item with other items Contractor did not supply; (iii) Agency’s failure to use any new or corrected versions of the item made available by Contractor; or (iv) Contractor’s adherence to Agency’s specifications or instructions.</u> The warranty provided in this subsection shall be perpetual, shall not be subject to the contractual Warranty Period, and shall survive termination of this Contract. The foregoing remedies provided in this subsection shall be in addition to and not exclusive <u>and in lieu of other remedies available to the Agency and shall survive termination of this Contract.</u> Reason: see note above.</p>	
<p>Sample Contract, Section 2.11.4.2, page 40</p>	<p>See next column.</p>	<p>Proposed additions and deletions: <u>“In all material respects</u> meet and conform to and operate in accordance with During the Warranty Period the Contractor shall, at its expense, repair, correct or replace any Deliverable that contains or experiences material Deficiencies or fails <u>in all material respects</u> to meet, conform to or operate in accordance with Specifications within five (5) Business Days of receiving notice of such Deficiencies or failures from the Agency or within such other <u>reasonable</u> period as the Agency specifies in the notice <u>and the parties mutually agree upon in consideration of the complexity of the Deficiency....</u> The foregoing shall not constitute the Agency’s an exclusive remedy with respect to breaches of the foregoing warranty under this Contract, and the Agency shall be entitled to pursue any other available contractual, legal, or equitable remedies. The Contractor shall be available at all reasonable times <u>during the Warranty Period</u> to assist the Agency with questions, problems, and concerns about the Deliverables, to inform the Agency promptly of any known Deficiencies in any Deliverables, <u>and</u> repair and correct any Deliverables not performing in accordance with the warranties contained in this Contract, notwithstanding that such Deliverables may have been accepted by the Agency; <u>and provide the Agency with all necessary materials with respect to such repaired or corrected Deliverable.</u></p>	<p>See note above.</p>

		Reason: see note above.	
Sample Contract, Section 2.11.7, page 41	See next column.	Proposed addition: <u>“To the extent Contractor has the legal right to do so, Contractor agrees to assign or pass through to Agency or otherwise make available for the benefit of Agency, any manufacturer’s or supplier’s warranty applicable to any third-party software, hardware or equipment provided by Contractor under the Contract. Contractor does not itself give or make any warranty of any kind with respect to third-party software, hardware or equipment.”</u> Reason: see note above.	See note above.
Sample Contract, Section 2.12.1, page 41	See next column.	Proposed addition: “Absent more specific Acceptance Criteria in the Special Terms, following delivery of any Written Deliverable pursuant to the Contract, the Agency will notify the Contractor whether or not the Deliverable meets contractual specifications and requirements <u>in accordance with the Acceptance Plan</u> . Written Deliverables shall not be considered accepted by the Agency, nor does the Agency have an obligation to pay for such Deliverables, unless and until the Agency has notified the Contractor of the Agency’s Final Acceptance of the Written Deliverables <u>in accordance with the Acceptance Plan</u> .” Reason: See note above.	See note above.
Sample Contract, Section 2.12.2, page 41	See next column.	Proposed addition and deletion: “Except as otherwise specified in the Scope of Work <u>or the Acceptance Plan</u> , all Deliverables pertaining to software and related hardware components (“Software Deliverables”) <u>identified in the Contract as being subject to Acceptance</u> shall be subject to the Agency’s Acceptance Testing and Acceptance, <u>in accordance with this Section 2.12.2 unless otherwise specified in the Scope of Work</u> ... Notwithstanding the provisions of Section 2.5.1, Termination for Cause by the Agency, of this Contract, The Agency may terminate this Contract pursuant to this section without providing the Contractor with any notice or opportunity to cure provided for in the termination provisions of this Contract....” Reason: see note above	See note above.
Sample Contract, Section 2.12.3, page 42	See next column.	Proposed additions deletion: The Contractor’s receipt of any notice of Acceptance, including Final Acceptance, with respect to any Deliverable shall not be construed as a waiver of any of the Agency’s rights to enforce the terms of this Contract or require performance in the event the Contractor breaches this Contract or any Deficiency is later discovered with respect to such Deliverable. Reason: see note above.	See note above.

Sample Contract, Section 2.13.3, page 42	See next column.	Proposed deletion: The contractual obligations of the Agency are expressly stated in this document. The Bid Proposal does not create any express or implied obligations of the Agency. Reason: see note above.	See note above.
Sample Contract, Section 2.13.11, page 43	See next column.	Proposed additions: "Assignment and Delegation. The Contractor may not assign, transfer, or convey in whole or in part this Contract without the prior written consent of the Agency, <u>which approval shall not be unreasonably withheld.</u> For the purpose of construing this clause, a transfer of a controlling interest in the Contractor shall <u>not</u> be considered an assignment. The Contractor may not delegate any of its obligations or duties under this Contract without the prior written consent of the Agency. The Contractor may not assign, pledge as collateral, grant a security interest in, create a lien against, or otherwise encumber any payments that may or will be made to the Contractor under this Contract." Reason: See note above.	See note above.
Sample Contract, Section 2.13.21, page 44	See next column.	Proposed addition: " <u>Except as otherwise expressly provided in this Contract, the various right, powers, options, elections, and remedies of any party provided in this agreement</u> " Reason: see note above.	See note above.
Sample Contract, Section 2.13.22, page 44	See next column.	Proposed deletions: " Time is of the essence with respect to the Contractor's performance of the terms of this Contract. The Contractor shall ensure that all personnel providing Deliverables to the Agency are responsive to the Agency's requirements <u>as specified in the Contract, and requests in all material respects.</u> " Reason: see note above.	See note above.
Sample Contract, 2.13.28, page 46	See next column.	Proposed deletion: " The Agency reserves the right to require Contractor to conduct and/or request the disclosure certify the results of criminal history and other background investigation of the conducted or commissioned by Contractor, of its officers, directors, shareholders, and the Contractor's staff, agents, or subcontractors assigned retained by the Contractor for the performance of Contract services. " Reason: see note above. Also, it is CGI's general practice not to permit its personnel to be subject of background checks conducted by clients or to make background checks conducted by CGI available to clients except through certification of results.	See note above.
Sample Contract, Section 2.13.30, page 46	See next column.	Proposed addition: "Obligations Beyond Contract Term. This Contract shall remain in full force and effect to the end of the specified term or until terminated pursuant to this Contract. All obligations of the Agency and the Contractor incurred or existing under this Contract as of the date of expiration or termination <u>that contemplate survival</u> will survive the	See note above.

		<p>termination or expiration of this Contract.” Reason: see note above.</p>	
<p>Sample Contract, 2.13.33, page 46</p>	<p>See next column.</p>	<p>Proposed addition and deletion: “...If a Force Majeure delays or prevents the Contractor’s performance, the Contractor shall <u>promptly immediately</u> use <u>commercially reasonable</u> its best efforts to directly provide alternate, and to the extent possible, comparable performance....” Reason: see note above.</p>	<p>See note above.</p>
<p>2.13.35, page 46</p>	<p>See next column.</p>	<p>Proposed addition: “Repayment Obligation. In the event that any State and/or federal funds are deferred and/or disallowed as a result of any audits or expended in violation of the laws applicable to the expenditure of such funds as the result of <u>negligence or intentional misconduct of Contractor or a subcontractor</u>, the Contractor shall be liable to the Agency for the full amount of any claim disallowed and for all related penalties incurred. The requirements of this paragraph shall apply to the Contractor as well as any subcontractors. Reason: See note above.</p>	<p>See note above.</p>
<p>Missing Term: Limitation of Liability</p>		<p>Proposed addition: <u>“Contractor shall not be liable for indirect, special, incidental, punitive, or consequential damages, even if advised of the possibility of such damages, including, without limitation, any such damages arising out of the Agency’s use of or inability to use the solution.</u></p> <p><u>“Contractor’s liability to the Agency and the State arising out of this Contract shall not exceed, in the aggregate for all claims, the total aggregate amount paid to the Agency under this Contract, amendments or change orders related thereto (collectively, “Contract Documentation”).</u></p> <p><u>“Notwithstanding anything to the contrary in this Contract, the limitations, exclusions and disclaimers of damages and liability specified in this Section shall not apply to any losses, damages, expenses, costs, settlement amounts, judgments, suits, actions, claims, or any other liability arising out of or relating to: (i) intentional or willful misconduct, bad faith or fraud of Contractor, its employees, officers, directors, agents, contractors or subcontractors; and (ii) Contractor’s indemnification obligations set forth in this Contract. For purposes of this Contract, ‘bad faith’ shall mean fraudulent deception or intentional or malicious abandonment.</u></p> <p><u>“In no event shall the Agency or the State be liable for indirect, special, incidental or consequential damages, even if advise of the possibility of such damages.</u></p>	<p>See note above.</p>

MED-012-003 Electronic Health Records Medicaid Incentive Payment Administration Tool

		<u>Reason: see note above.”</u> Reason: see note above.	
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BID PROPOSAL CERTIFICATION

By signing below, Bidder certifies that:

- Bidder accepts and will comply with all Contract Terms and Conditions contained in the Sample Contract without change except as otherwise expressly stated in the Primary Bidder Detail Form & Certification;
- Bidder has reviewed the Additional Certifications, which are incorporated herein by reference, and by signing below represents that Bidder agrees to be bound by the obligations included therein;
- Bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;
- No cost or pricing information has been included in the Bidder’s Technical Proposal;
- Bidder has received any amendments to this RFP issued by the Agency;
- Bidder either is currently registered to do business in Iowa or agrees to register if Bidder is awarded a Contract pursuant to this RFP;
- The person signing this Bid Proposal certifies that he/she is the person in the Bidder’s organization responsible for, or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive agreements outlined above;
- Bidder specifically stipulates that the Bid Proposal is predicated upon the acceptance of all terms and conditions stated in the RFP and the Sample Contract without change except as otherwise expressly stated in the Primary Bidder Detail Form & Certification. Objections or responses shall not materially alter the RFP. All changes to proposed contract language, including deletions, additions, and substitutions of language, must be addressed in the Bid Proposal;
- Bidder certifies that the Bidder organization has sufficient personnel resources available to provide all services proposed by the Bid Proposal, and such resources will be available on the date the RFP states services are to begin. Bidder guarantees personnel proposed to provide services will be the personnel providing the services unless prior approval is received from the Agency to substitute staff;
- Bidder certifies that if the Bidder is awarded the contract and plans to utilize subcontractors at any point to perform any obligations under the contract, the Bidder will (1) notify the Agency in writing prior to use of the subcontractor, and (2) apply all restrictions, obligations, and responsibilities of the resulting contract between the Agency and contractor to the subcontractors through a subcontract. The contractor will remain responsible for all Deliverables provided under this contract.
- Bidder guarantees the availability of the services offered and that all Bid Proposal terms, including price, will remain firm until a contract has been executed for the services contemplated by this RFP or one year from the issuance of this RFP, whichever is earlier; and,
- Bidder certifies it is either a) registered or will become registered with the Iowa Department of Revenue to collect and remit Iowa sales and use taxes as required by Iowa Code chapter 423; or b) not a “retailer” of a “retailer maintaining a place of business in this state” as those terms are defined in Iowa Code subsections 423.1(42) & (43). The Bidder also acknowledges that the Agency may declare the bid void if the above certification is false. Bidders may register with the Department of Revenue online at:<http://www.state.ia.us/tax/business/business.html>.

By signing below, I certify that I have the authority to bind the Bidder to the specific terms, conditions and technical specifications required in the Agency’s Request for Proposals (RFP) and offered in the Bidder’s Proposal. I understand that by submitting this Bid Proposal, the Bidder agrees to provide services described herein which meet or exceed the requirements of the Agency’s RFP unless noted in the Bid Proposal and at the prices quoted by the Bidder. I certify that the contents of the Bid Proposal are true and accurate and that the Bidder has not made any knowingly false statements in the Bid Proposal.

Signature:	
Printed Name/Title:	Holli Ploog, Vice President
Date:	

4 APPROACH TO MEETING DELIVERABLES

The bidder shall address each Deliverable that the successful contractor will perform as listed in Section 1.3 (Scope of Work) by first restating the Deliverable from the RFP and then explaining the bidder's planned approach to meeting each contractor Deliverable immediately after the restated text. Bid Proposals shall be fully responsive and must not merely repeat the Deliverable.

Bidders are given wide latitude in the degree of detail they offer or the extent to which they reveal plans, designs, examples, processes, and procedures. Bidders do not need to address any responsibilities that are specifically designated as Agency responsibilities.

Note:

- Responses to Deliverables shall be in the same sequence as presented in the RFP.
- Bid Proposals shall identify any deviations from the requirements the bidder cannot satisfy.
- Bid Proposals shall not contain promotional or display materials unless specifically required.
- If a bidder proposes more than one method of meeting the RFP requirements, each method must be drafted and submitted as separate Bid Proposals. Each will be evaluated separately.

4.1 DELIVERABLES

4.1.1 MEDICAID INCENTIVE360 PORTAL

The Contractor shall provide a system that will manage all aspects of the EHR incentive program. The Contractor will be obligated to provide the following, although the Contractor's obligations may not be limited to the following:

CGI's Medicaid Incentive360 manages all aspects of the Medicaid EHR Incentive Program. Our solution is designed as a "solution in a box" that allows Iowa to quickly establish a state of the art technology to administer the program with minimal disruption to the core business focus of the Iowa Medicaid Enterprise (IME). Medicaid Incentive360 participant states lead the nation in the distribution of qualified incentive funds to the validated Eligible Providers (EP) and Eligible Hospitals (EH). To date, Medicaid Incentive360 has managed the compliant distribution of more than \$160M to more than 1,200 EPs and 110 EHs.

Our Medicaid Incentive360 web-based solution consists of four functional components:

- ▶ Provider Portal
- ▶ Business Services Portal
- ▶ Integration Services
- ▶ Business Intelligence/Reporting

Out-of-the-box, CGI's Medicaid Incentive360 solution meets or exceeds Iowa's requirements for the EHR Medicaid Incentive Payment Administration Tool with minimal development necessary to integrate the solution to Iowa's existing environment and business processes.

These core technical components can all be hosted in the Iowa environment. Rounding out our service offering, but not included in scope of the Iowa RFP, is our Business Services Center, which provides a wide array of program expertise based services necessary to administer the program and facilitate broad

embracement and righteous participation. While these services are not included in the scope of our proposal, we would be happy to further discuss the benefits that they could provide for IME at a later date.

The following diagram, Exhibit 4-1, presents a visual overview of the different features of the different Medicaid Incentive360 system components, which we further detail in this section.

Exhibit 4-1: Medicaid Incentive360 Functional Overview

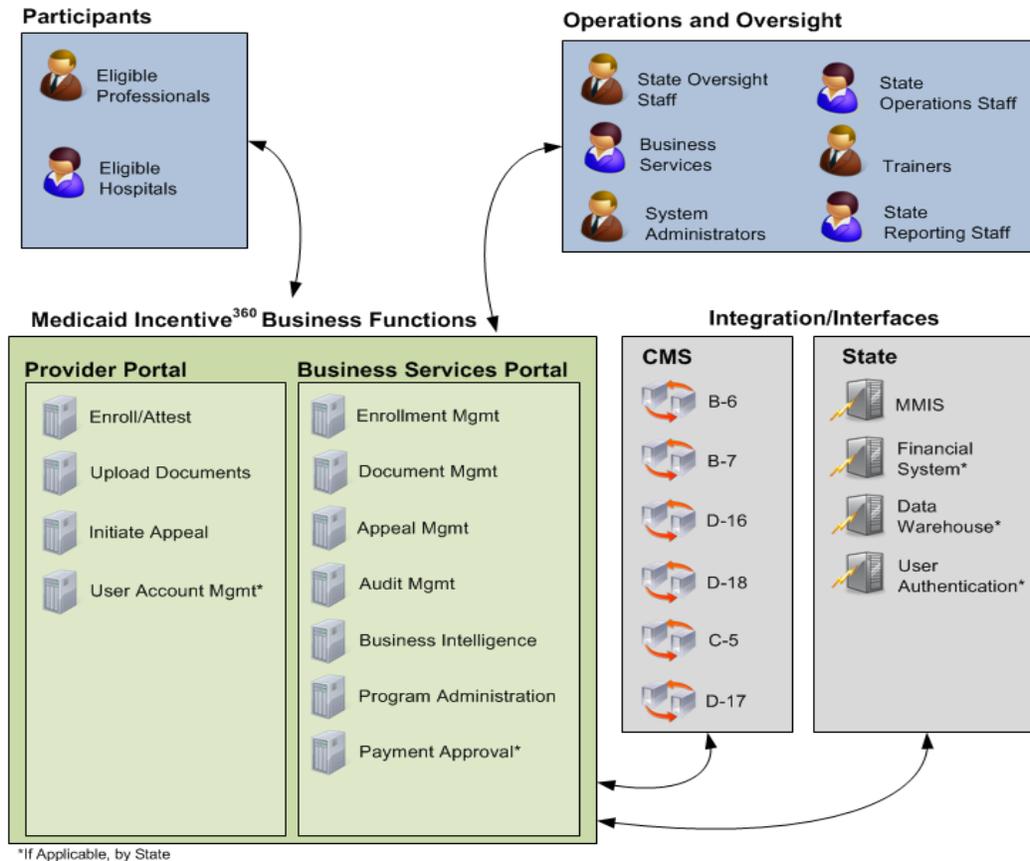
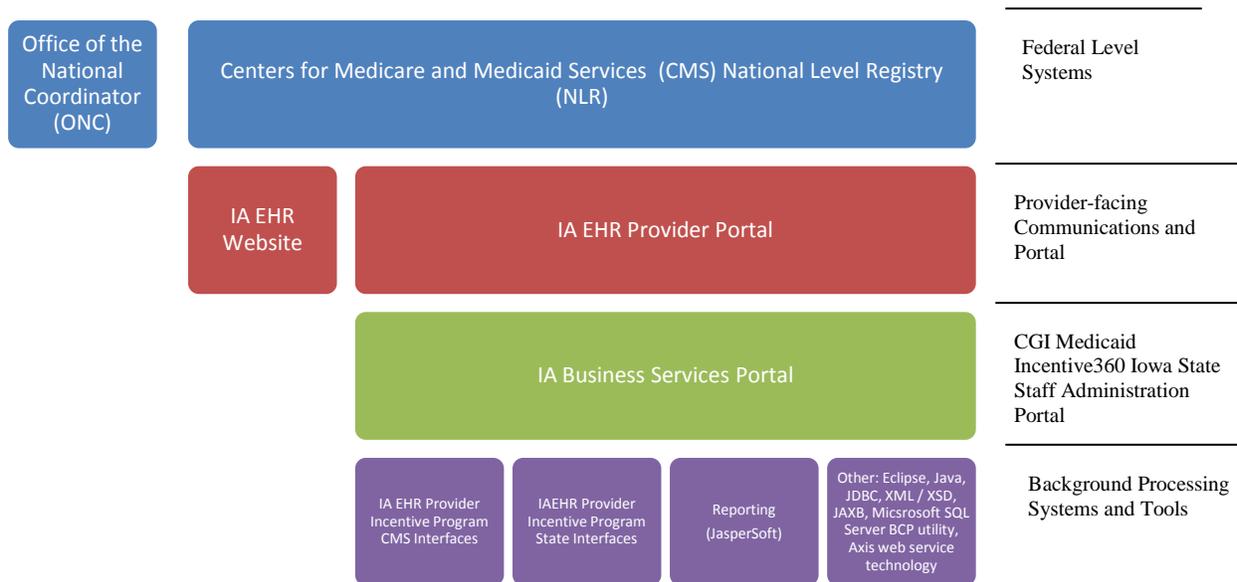


Exhibit 4-2 presents the overall relationship between the different tools/portals available for the EHR Medicaid Incentive Payment Administration Tool, starting with the federal level programs and moving through components of the solution, including background systems. Training will provide detailed descriptions of how each system interacts with the users and other systems.



Exhibit 4-2: Tools/Portals Overview Diagram



Provider Portal Overview

The Medicaid Incentive360 application has been architected, developed, implemented and supported as a Software as a Service (SaaS) solution for multiple states, while physically segregating and protecting each states’ data to enforce appropriate access control. In this response, we present the option for Iowa to host the application in the Iowa environment.

Our portal offers participants a single location to manage their participation in the program from registration through payment. For easier navigation and to lessen the burden on providers, our web portal has a user interface similar in look and feel to the Federal web portal for registration. In addition to the provider web portal, our solution includes a service portal that is configurable by role to support the state in managing the administrative functions and workflow associated with servicing the enrollments. Our use of current web technologies facilitates the introduction of changes to the portal based on future requirements from CMS. The application navigation architecture enables new modules to be plugged in to the application workspace to enable new functional units to be rolled into the application and configured for the appropriate roles without rewiring core code or companion modules.



At the foundation of the web portal and in support of our entire Medicaid Incentive360 solution resides a robust data repository that can accommodate both structured and unstructured data for storing demographic, eligibility, and payment information. Our solution integrates the NLR interfaces and provides a history of all data entered and activities completed. This solution supports all reporting and site content including provider dashboards displaying all key performance indicators. The components of our solution are scalable and extensible to effectively handle increased volumes and flexible in order to accommodate additional functional requirements as they arise.

Medicaid Incentive360's Provider Portal meets all the requisite steps of the provider application and attestation process for the current program year 1, and will be enhanced to meet the future requirements encapsulated in Stages 2 and 3 of Meaningful Use as defined by CMS. Medicaid Incentive360 contains all of the business rules associated with determining a participating Eligible Professional's (EP) or Eligible Hospital's (EH) eligibility to receive an incentive payment as well as the resulting calculation of the entitled payment. In accordance with the progressive program parameters, providers will initially be responsible for self-reporting (i.e., attesting) their eligibility data in the program which will drive the subsequent payment calculation. Starting in 2012, providers will be required to submit their meaningful use and clinical quality measure results and this will facilitate many aspects of their program eligibility.

The Medicaid Incentive360 Provider Portal has been designed to reflect the fact that most providers, EPs and EHs, will only access it once per year making ease of use a primary consideration. The provider portal web screens include extensive descriptions and instructions and use industry standard layouts and widgets that virtually eliminate the need to formal training, much like most e-commerce applications used by the same user community. If a provider portal user does have question, online help is available to provide further guidance as well as access to Frequently Asked Questions (FAQs) to facilitate the completion of the registration, enrollment and attestation process.

Provider Portal utilizes an intuitive user interface that allowed more than 99.6% of 1,350 providers to complete the enrollment, attestation and receive payment without requiring technical support.

The following screenshot, Exhibit 4-3, presents the initial Enrollment page, which provides exemplifies our design concepts that are manifested throughout our application to facilitate ease of use as well as provide the user a constant, clear indication of their status and context.



Exhibit 4-3: Sample State Enrollment Page – Status Context

Home
Enrollment
Documents
Appeals
Status
Account Management

Current Enrollment Status

Program Year: 2011 Participation Year: 1

Step 1 - Registration Verification Status: Not Completed

Step 2 - Volume Determination Status: Not Completed

Step 3 - Adopt, Implement, Upgrade Status: Not Completed

Step 4 - EHR Payment Determination Status: Not Completed

Step 1 - Provider Registration Verification

Confirm your provider registration information that will be used to determine your eligibility for this program.

Registration Information

National Provider Information

Attest if you are a Pediatrician who treats patients under 21 years of age.

Name: Bill Lawson Sr.	Provider Type: Physician-MD
Address: 287 Rangle Drive, Suite 2 San Antonio, TX 39654-9087	Provider Specialty: Physician-DO, Oncologist
Phone #: (512) 619-6498 Ext: 6734	*Pediatrician: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Tax ID: xxx-xx-6743 (SSN)	CMS Confirmation #: 5923710625
NPI: 2987456094	

State Provider Information

Attest if you are a hospital based provider or if you work more than 50% for six months in a FQHC/RHC. If practicing predominately in FQHC/RHC you are required to select your affiliated FQHC/RHC.

Enrollment ID: 1928472 Alt Phone Number: (703) 481-3278 Ext: 3456 Email Address: BillLawson@DHClincs.com

*Hospital Based: Yes No You are hospital based if > 90% Medicaid services are provided in the following two place of service (POS) codes for HIPAA standard transactions: 21--Inpatient Hospital, 23--Emergency Room.

*Practices in FQHC or RHC: Yes No Select FQHC/RHC

Affiliated FQHC or RHC: Benham Community Hlth Ctr, Kaufman Community Hlth Ctr

Group Practice

Select if you are attesting as part of a group practice. If Yes, the Select Group ID and Members button will be enabled to allow you to select the Group MMIS ID and the group members participating in this incentive program. This will only be available to the first member of a group, referred to as the "Group Enroller". If you feel you have been selected as part of a group erroneously, please contact the Group Enroller listed below.

*Reporting as Group: Yes No

Group MMIS Provider ID: 849036766 Select Group ID and Members	Group TIN: 11-7643214 (EIN)
Group Name: CL Clinics of San Antonio	Group NPI: 8210587129
Group Address: 71 Jody Drive, Suite A San Antonio, TX 39654-9087	Group Enroller: Bill Lawson Sr.

Payment Assignment

Select your payee MMIS provider id by clicking the button below.

Payee Name: CL Clinics of San Antonio

*Payee MMIS Provider ID: 849036766 Select MMIS ID

Payee Address: 71 Jody Drive, Suite A
San Antonio, TX 39654-9087

Payee TIN: 11-7643214 (EIN)
Payee NPI: 8210587129

Exclusions

Federal Exclusions Exist: Yes [Details](#)

State Exclusions Exist: No

Previous
Save & Continue

[Home](#) | [Contact Us](#) | [Connect with Texans](#) | [Homeland Security](#) | [Internet Policy](#) | [Statewide Search](#) | [Texas Gov](#) | [File-viewing Information](#)

In the preceding screen shot, you can see the six functions available to the EP or EH. These tabs are included on each application page in the Provider Portal.

- ▶ **Home** – Entry point for the system
- ▶ **Enrollment** – Widget driven workflow to guide the program participant through the steps for enrollment

- ▶ **Documents** – Provides access to all documents that have been uploaded, as well as the ability to upload additional documents as appropriate.
- ▶ **Appeals** – Provides the ability for a program participant to manage their appeals from filing to providing additional information through resolution and even escalation.
- ▶ **Status** – Used to confirm the status of a completed enrollment, including the payment status as well as projected payment date.
- ▶ **Account Management** – Provides the ability to update contact information, including email addresses, change password, etc.

“We are participating in the EHR Incentive Program in 16 states, and the Texas Solution is by far the most intuitive and easiest to use.”
- Community Health Systems, Inc.

Highlighted in this screen shot by the red box is the provider context status block that is included in each of the Enrollment pages. Included in this context box are the provider’s name and NPI, as well as the current status of the four stages of the enrollment process. This helps the provider keep track of where they are in the process, as well as what is remaining to reach completion.

In the remainder of this sample page, you see the provider information that has been received from CMS through the National Level Repository (NLR) B-6 Registration interface and pre-populated in the MI360 system. If the information is still accurate, the provider can just continue without requiring duplicate data entry. If something has changed, the provider can perform the updates and proceed with the enrollment process. This is an example of another design philosophy of eliminating duplicate data entry.

We provide more sample screen shots throughout the remainder of our response to illustrate the unique design and demonstrate the focus on ease of use in conjunction with maintaining necessary program data and business rule integrity.

Business Services Portal Overview

As states prepare to support the Medicaid EHR Incentive Program, the majority of the focus is placed on the Provider Portal functionality to support provider enrollment and attestation. Equally important is the system and program administration functionality and features, including account management, provider inquiries, payment approval, initial and escalated appeals and audits. Medicaid Incentive360 provides this functionality in the Business Services Portal.

When designing our MI360 solution, we placed significant emphasis on providing easy to use, feature-rich functionality enabling the incentive program administrators the ability to enforce the program rules and regulations without unduly delaying the processing of the validated payments. Access to these features is managed by role-based user privileges and multi-factor system authentication, preventing unauthorized access and privileges to these powerful

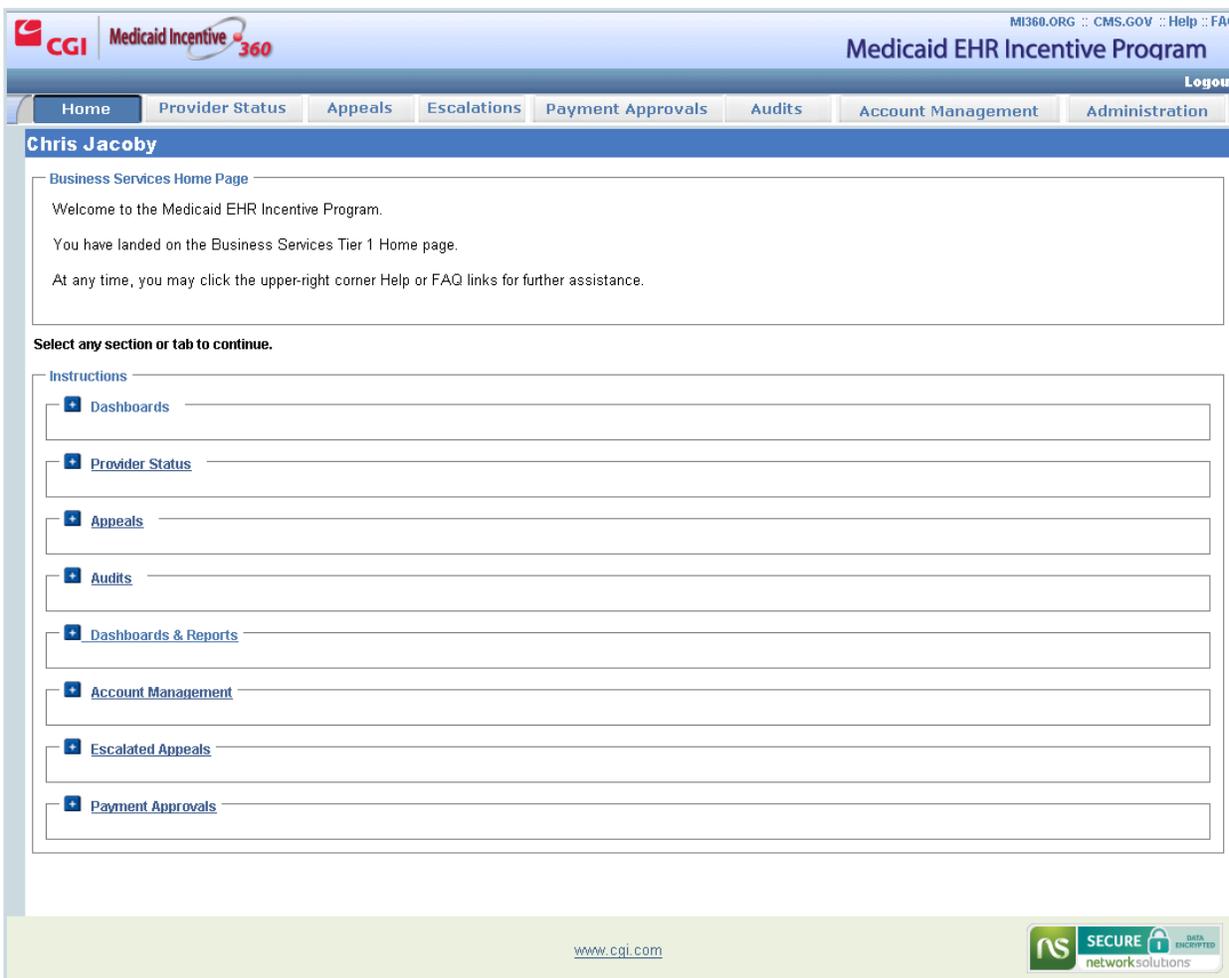
Business Services Portal provides the ability to efficiently monitor and enforce program rules and regulations. It utilizes multi-factored authentication to prevent unauthorized access and it is designed to allow separation and delegation of duties for appeals, audits and oversight.

features.

The Business Services Portal has been designed with flexibility to support different Medicaid EHR Incentive Program administration responsibility delegation models such as using a vendor to perform some or all of the program administration activities, or different functional groups within the state Medicaid management organization. Separation of duties and responsibilities is managed through the role-based privilege management, providing the ability to segregate the responsibilities for managing first level appeals from escalated appeals as well as audit management and oversight.

Exhibit 4-4 provides a screen print of the Business Services home page, presenting the different functions available to authorized users. We further elaborate the specific functions and features of the Business Services Portal in our subsequent response to the requirements for the EHR program administration tools and services.

Exhibit 4-4: Business Services Portal Home Page



The screenshot shows the Business Services Portal Home Page. At the top, there is a header with the CGI logo, "Medicaid Incentive 360", and "Medicaid EHR Incentive Program". A navigation bar includes links for Home, Provider Status, Appeals, Escalations, Payment Approvals, Audits, Account Management, and Administration. The user is logged in as Chris Jacoby. The main content area contains a welcome message and a list of sections to continue, including Dashboards, Provider Status, Appeals, Audits, Dashboards & Reports, Account Management, Escalated Appeals, and Payment Approvals. The footer includes the website URL www.cgi.com and a security logo for network solutions.

Integration Services Overview

The Medicaid EHR Incentive Program is dependent upon the tightly choreographed and secured data exchanges among multiple contributing entities. CGI's Medicaid Incentive360 solution has been successfully operating in multiple states through the careful integration of data from three primary sources, in addition to ONC for the Certified Health IT Product list:

- ▶ CMS NLR Registration, Eligibility and Payment Validation
- ▶ State Medicaid EHR Incentive Program – Enrollment, AIU, Meaningful Use Attestation, and Incentive Payment Amounts
- ▶ State Systems – MMIS data, Financial Systems

The integration between these systems is accomplished through a set of precise interface transactions established by CMS as well as a set of system tools to integrate with the different state systems used to provide data to validate the eligibility of the providers.

CGI has developed a deep understanding of the CMS NLR interfaces and is confident that we can complete the required NLR interface tests with CMS with unparalleled expediency and efficiency. In fact, CMS has waived the requirement for Dev Testing for future Medicaid Incentive360 implementations, allowing us to proceed directly to VAL testing. This significantly reduces the amount of time and effort required to achieve CMS interface certification.

In addition to the federal system interfaces, Medicaid Incentive360 provides the capability to integrate with a number of different state specific systems to collect and aggregate data that is used in the eligibility verification and fraud identification processes. Medicaid Incentive360 is MMIS agnostic and is capable of supporting either web-service or data file transfer approaches. This technology agnostic capability minimizes the constraints and effort imposed upon the state in supporting the implementation and ongoing operations.

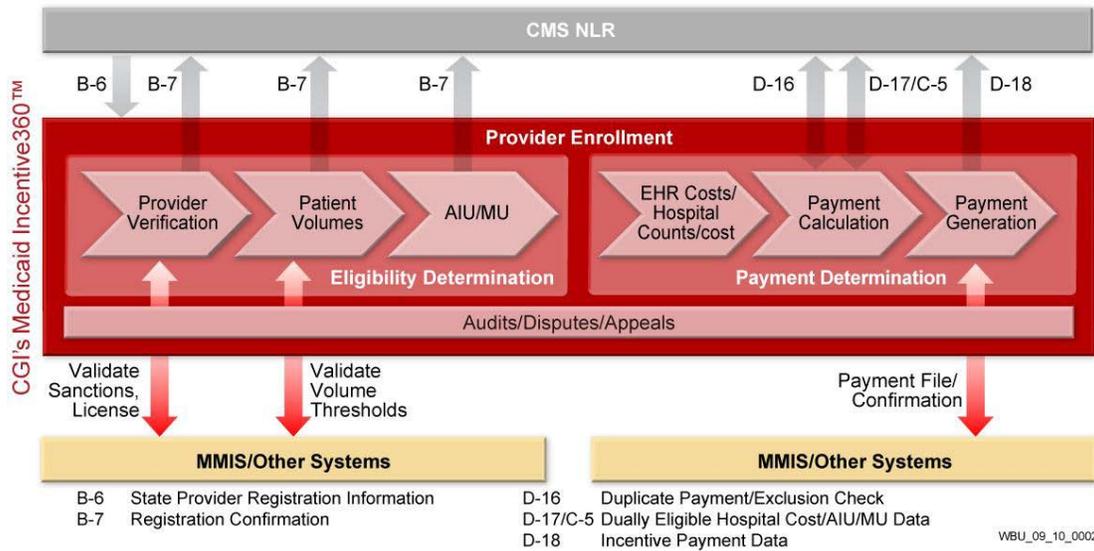
Exhibit 4-5 presents a visualization of the different interface touch points between Medicaid Incentive360, the CMS NLR and State systems. We further elaborate the details of our proven, sophisticated integration engine in the subsequent responses to the interface specific requirements in this section.

Proven, secure Integration Engine features:

- Received a waiver from CMS for DEV phase of NLR testing.
- Supports web-services as well as file transfers.
- Successfully operating in different states with different MMIS systems.
- Supports integration with multiple data sources.



Exhibit 4-5: Medicaid Incentive Interface Overview



Reports/Business Intelligence Overview

CGI’s Reporting and Business Intelligence philosophy is simple. We empower the states to access and leverage the Medicaid EHR Incentive Program information from their state repository to improve simplify the program administration and improve the efficiency and quality of services to their stakeholder community.

The Medicaid Incentive360 Reporting and Business Intelligence engine has been designed to support the generation of standard reports to facilitate the management of the day-to-day operations as well as flexibility to access data as necessary to respond to unanticipated inquiries or business requirements. CGI has designed and refined a base set of dashboards and standard reports that will provide Iowa with multiple levels of insight into the progress of the program across all of the project domains. As CMS guidance and regulations evolve, our base set of reports will also evolve to meet the needs of our participant states. As new reports are generated, we add them to the library for all states’ benefit.

We also provide an ad-hoc reporting tool that empowers the state business users to access the ever-increasing amount of data that is collected and maintained. This tool provides the state with direct access to the information without ongoing dependency on the vendor for support.

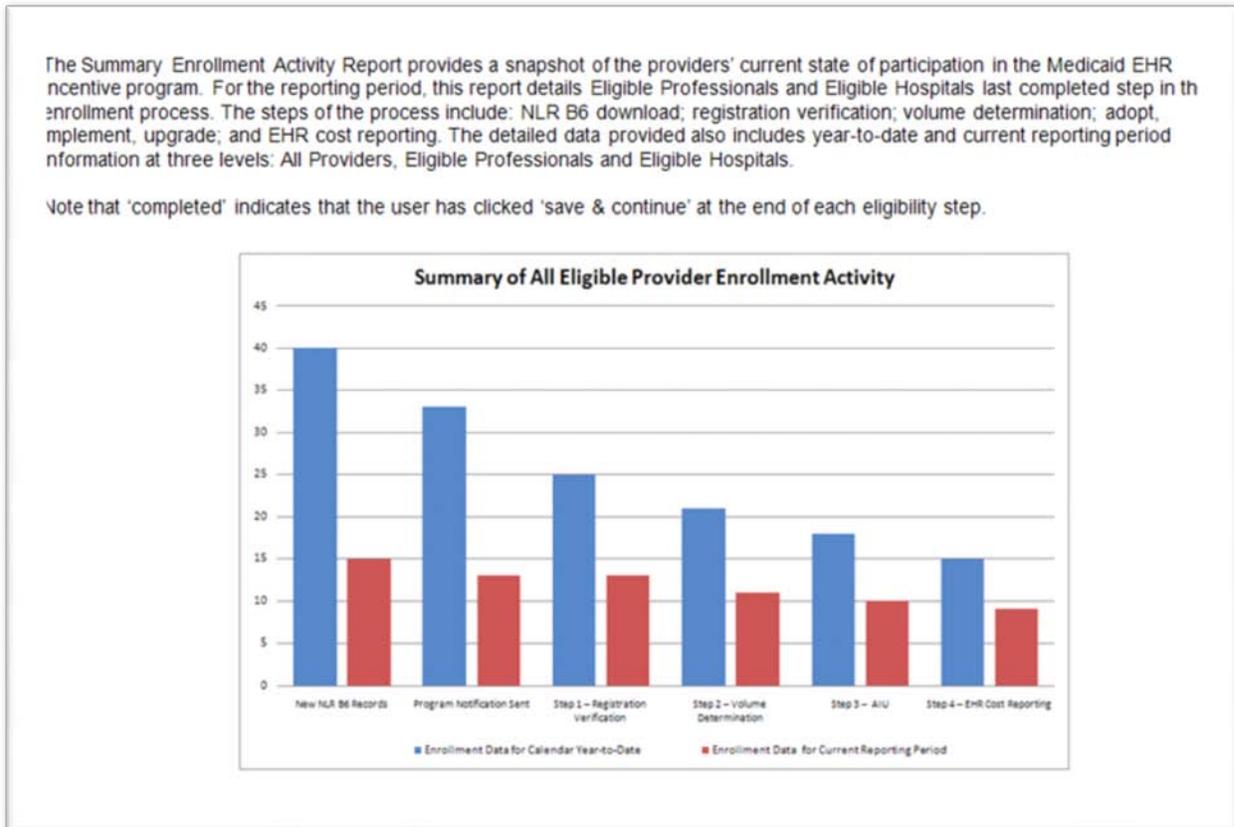
In addition to the different reporting tools, CGI has designed a base set of dashboards that provide multiple levels of insight into the progress of the program across all of the project domains. Like the

- **Reporting Tools empower state access to program information to support business needs.**
- **Includes an evolving library of standard reports and dashboards.**
- **Platform grows to meet the needs and capabilities of the users.**

reports, these dashboards continue to evolve to support the evolving program requirements and needs of the states and will be shared across all of the Medicaid Incentive360 clients.

Exhibit 4-6 provides a sample of the standard Registration Summary Report. We provide further details about our reporting capability in our responses to the reporting requirements in this section.

Exhibit 4-6: Registration Summary Report



1. Provide a web portal for provider attestation. The portal must:
 - a. Allow for secure authorization and authentication of the provider.

Provider program eligibility begins with the receipt of the NLR B-6 Add interface transaction from CMS. Upon the receipt of the B-6, Medicaid Incentive360 a crosswalk of the B-6 provider NPI and TIN information against the state provided data from MMIS and other sources to confirm status and general eligibility for the program. This includes identifying any providers with active state sanctions and/or exclusions at the time of enrollment. If they are determined to have a sanction or exclusion, they are not allowed to proceed with the program resolution until they are resolved as verified by Medicaid Incentive360. They will receive an email notification describing the impediment to proceeding with the program.



After successfully completing the initial crosswalk and transmitting a “Welcome to the Program” email to the provider, Medicaid Incentive360 application utilizes multiple layers of security to protect the integrity of the program participants, the program data as well as the distribution of the program incentive funds. From the provider management and authentication perspective, Medicaid Incentive360 can be implemented as either a totally stand-alone application, supporting the user access administration entirely within the application’s hardware and network domain, or can be integrated with your existing enterprise authentication protocol utilizing single-sign on.

For program participants/providers, the system includes a secure self-service registration process to allocate and manage logon accounts. The self-service registration requires the knowledge and entry of information that only the provider will have to establish the account. The application comes with a custom database repository for user credentials as the default security provider. Passwords stored in the repository are encrypted using strong encryption rather than a simple MD5 hash. The application requires a strong password composed of a configurable mix of mixed case alpha numeric and special characters. Configurable password expiration policy is supported. Successive invalid password entries are tracked and displayed to the user on successful logon along with the date and time of the most recent successful logon. The application can be configured to disable the account after a set number of unsuccessful logons. Every logon attempt is logged in the repository to facilitate review and reporting. We will work with IME to determine the preferred approach to maximize security and minimize unnecessary administrative overhead while complying with the program and State’s security policies.

Exhibit 4-7 presents a sample of the initial provider registration page that supports the account setup for providers whose B-6 add transaction successfully completed the cross-walk process.

Exhibit 4-7: Provider Registration Page

Warning Notice

The Medicaid EHR Incentive Program provides incentive payments to eligible professionals (EPs) and eligible hospitals (EHs) demonstrating adoption, implementation, or upgrading of certified electronic health record technology. You can use this System to register and participate in the program. Only authorized users have rights to access the Medicaid EHR Incentive System. If you do not have authorization, close this link and do not attempt to gain further access. Unauthorized access to this system is forbidden and will be prosecuted by law.

Registration

To complete Registration, please enter the following information, and click Register.

NPI:

TIN:

CMS Registration ID:

New Password:

Confirm Password:

For further assistance, please call 1-234-567-8901.

Password Requirements

Medicaid EHR Incentive Program passwords must comply with the following password requirements:

- All account passwords must have a minimum of eight characters.
- All account passwords must have a combination of at least three of the following four elements: (1) numeric; (2) upper case alphabetic; (3) lower case alphabetic; and (4) special character from the set of "!@#%*+~_".
- Account passwords will not contain portions of the login ID, personal names (e.g. family members or pets), or guessable dates (e.g. birth dates or anniversaries) and will not be constructed around a dictionary word regardless of language.
- Program users will not construct passwords that are identical to any of their previous twelve passwords.

www.cgi.com

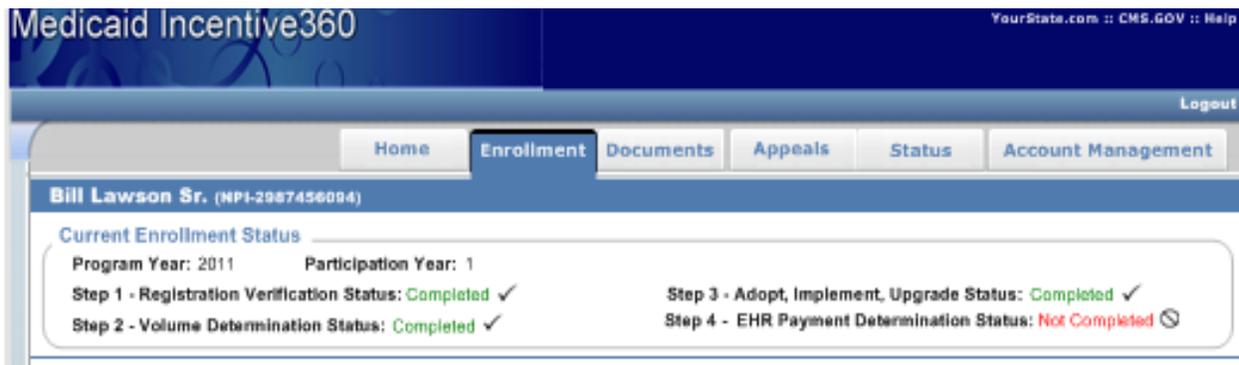


b. Display a provider identifier on each screen and printed pages.

Medicaid Incentive360 displays the Provider Name and NPI on all user interface pages to ensure context is always available, particularly important for participating groups that delegate the enrollment of multiple providers to an administrative staff member.

The following screen header layout, Exhibit 4-8, is consistent on all of the Provider Portal user interface pages. This standard style provides the program participant constant context of who is logged in (Bill Lawson Sr. NPI-2987456094), in addition to where they are in the process, Enrollment Step 3, and how much is left to be completed. This is important to prevent frustration and set appropriate expectations regarding the amount of work remaining to complete the enrollment.

Exhibit 4-8: Enrollment Status



c. Pre-populate with information from the CMS national level repository (NLR) and the Medicaid Provider directory.

CGI's Medicaid Incentive360 pre-populates the provider registration screens with the information from the CMS national level repository (NLR) through the B-6 interface transaction during the initial access. Per the CMS rule, Medicaid Incentive360 accepts and processes new records, modified records and deleted record requests received from the NLR.

The first step in the provider participation process is registering in the CMS National Level Repository (NLR). Upon successfully completing the NLR registration, CMS transmits a B-6 Provider Registration transaction to Medicaid Incentive360 with key provider demographic data that will be used to initiate the validation and registration processes in the State's Medicaid Incentive360 system. Medicaid Incentive360 maintains a historic record of all NLR interface records and then stores the data in the Medicaid Incentive360 database to support the registration.

When a provider accesses Medicaid Incentive360 for the first time, the provider data screens will be pre-populated with the information that is provided through the NLR transactions. The provider will have the opportunity to update some of the information, but will not be required to re-enter any data that has been propagated by the NLR transaction set.

Exhibit 4-9 presents the initial enrollment screen that the participating provider will see when they first access the system. This page is pre-populated with the data that was provided in the NLR B-6 interface transactions.



Exhibit 4-9: Initial Registration Screen – B6 Data

Home | Enrollment | Documents | Appeals | Status | Account Management

Bill Lawson Sr. (NPI-2987456094)

Current Enrollment Status

Program Year: 2011 Participation Year: 1

Step 1 - Registration Verification Status: Not Completed

Step 2 - Volume Determination Status: Not Completed

Step 3 - Adopt, Implement, Upgrade Status: Not Completed

Step 4 - EHR Payment Determination Status: Not Completed

Step 1 - Provider Registration Verification

Confirm your provider registration information that will be used to determine your eligibility for this program.

Registration Information

National Provider Information

Attest if you are a Pediatrician who treats patients under 21 years of age.

Name: Bill Lawson Sr.	Provider Type: Physician-MD
Address: 287 Rangle Drive, Suite 2 San Antonio, TX 39654-9087	Provider Specialty: Physician-DO, Oncologist
Phone #: (512) 619-6498 Ext: 6734	*Pediatrician: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Tax ID: xxx-xx-6743 (SSN)	CMS Confirmation #: 5923710625
NPI: 2987456094	

State Provider Information

Attest if you are a hospital based provider or if you work more than 50% for six months in a FQHC/RHC. If practicing predominately in FQHC/RHC you are required to select your affiliated FQHC/RHC.

Enrollment ID: 1928472 **Alt Phone Number:** (703) 481-3278 Ext: 3456 **Email Address:** BILLLawson@DHClincs.com

***Hospital Based:** Yes No You are hospital based if > 90% Medicaid services are provided in the following two place of service (POS) codes for HIPAA standard transactions: 21--Inpatient Hospital, 23-- Emergency Room.

***Practices in FQHC or RHC:** Yes No Select FQHC/RHC

Affiliated FQHC or RHC: Bonham Community Hlth Ctr, Kaufman Community Hlth Ctr

Group Practice

Select if you are attesting as part of a group practice. If Yes, the Select Group ID and Members button will be enabled to allow you to select the Group MMIS ID and the group members participating in this incentive program. This will only be available to the first member of a group, referred to as the "Group Enroller". If you feel you have been selected as part of a group erroneously, please contact the Group Enroller listed below.

***Reporting as Group:** Yes No

Group MMIS Provider ID: 849036768 Select Group ID and Members	Group TIN: 11-7643214 (EIN)
Group Name: CL Clinics of San Antonio	Group NPI: 8210587129
Group Address: 71 Jody Drive, Suite A San Antonio, TX 39654-9087	Group Enroller: Bill Lawson Sr.

Payment Assignment

Select your payee MMIS provider id by clicking the button below.

Payee Name: CL Clinics of San Antonio	
*Payee MMIS Provider ID: 849036768 Select MMIS ID	
Payee Address: 71 Jody Drive, Suite A San Antonio, TX 39654-9087	Payee TIN: 11-7643214 (EIN)
	Payee NPI: 8210587129

Exclusions

Federal Exclusions Exist: Yes [Details](#)

State Exclusions Exist: No

Previous
Save & Continue

[Home](#) | [Contact Us](#) | [Connect with Texans](#) | [Homeland Security](#) | [Internet Policy](#) | [Statewide Search](#) | [Texas Gov](#) | [File-viewing Information](#)

CGI's Medicaid Incentive360 also captures and retains information from the Medicaid Provider directory. Medicaid Incentive360 is designed to leverage provider demographic, enrollment, claim summary and status data from the state MMIS and Data Warehouses to facilitate the evaluation of the provider's qualification to participate in the program in accordance with the requirements as presented in the Final Rule. Specifically, Medicaid Incentive360 is designed to consume the following data from the local state MMIS environment:



- ▶ Provider Demographics Data – Used to validate the information provided on the NLR B-6 transactions and confirm that the provider is known and registered with the Iowa MMIS
- ▶ Provider Groups – Used to identify any group affiliations that a provider has
- ▶ Claims Summary – Summary of Medicaid claims by type and service location for the provider
- ▶ State Sanctions and Exclusions – May be included in the Provider Demographic Data

d. Allow attestation, based upon the provider type and year of the program participation.

Medicaid Incentive360 provides integrated attestation functionality based upon the provider type and year of the program participation. The following table, Exhibit 4-10, presents the current meaningful use attestation requirements based on payment year and the calendar/fiscal year:

Exhibit 4-10: Meaningful Use Attestation Requirements

	Program Year (FY – EH, CY – EP)						
Payment Year	2011	2012	2013	2014	2015	2016	2017+
1	AIU	AIU	AIU	AIU	AIU	AIU	X
2		Stage 1 MU (90 Days)					
3			Stage 1 MU Full Year				
4				Stage 2 MU Full Year	TBD	TBD	TBD
5					TBD	TBD	TBD
6						TBD	TBD
7							TBD

In accordance with the Final Rule, and subsequent addenda, year 1 attestation for both EP and EH can be either Adopt, Implement or Upgrade, or Stage 1 Meaningful Use attestation for a continuous 90 day period within the payment year. Attestation for Payment Year 2 is required to be at a minimum, 90 consecutive days of Stage 1 Meaningful Use Criteria as defined in the Final Rule. Medicaid Incentive360 is designed to enforce the appropriate attestation requirements based on the provider type and program year, preventing a participating provider from submitting an enrollment without meeting the statutory MU requirements. As of the time of publication of this proposal, only Stage 1 Meaningful Use Requirements have been defined.



Medicaid Incentive360 will continue to evolve to meet the incremental Meaningful Use requirements and enforcement of the EP and EH participation and demonstration as defined by CMS. As of proposal submission time, the design for Stage 1 Meaningful Use has been submitted to CMS for review and approval on behalf of the states of Texas and Ohio.

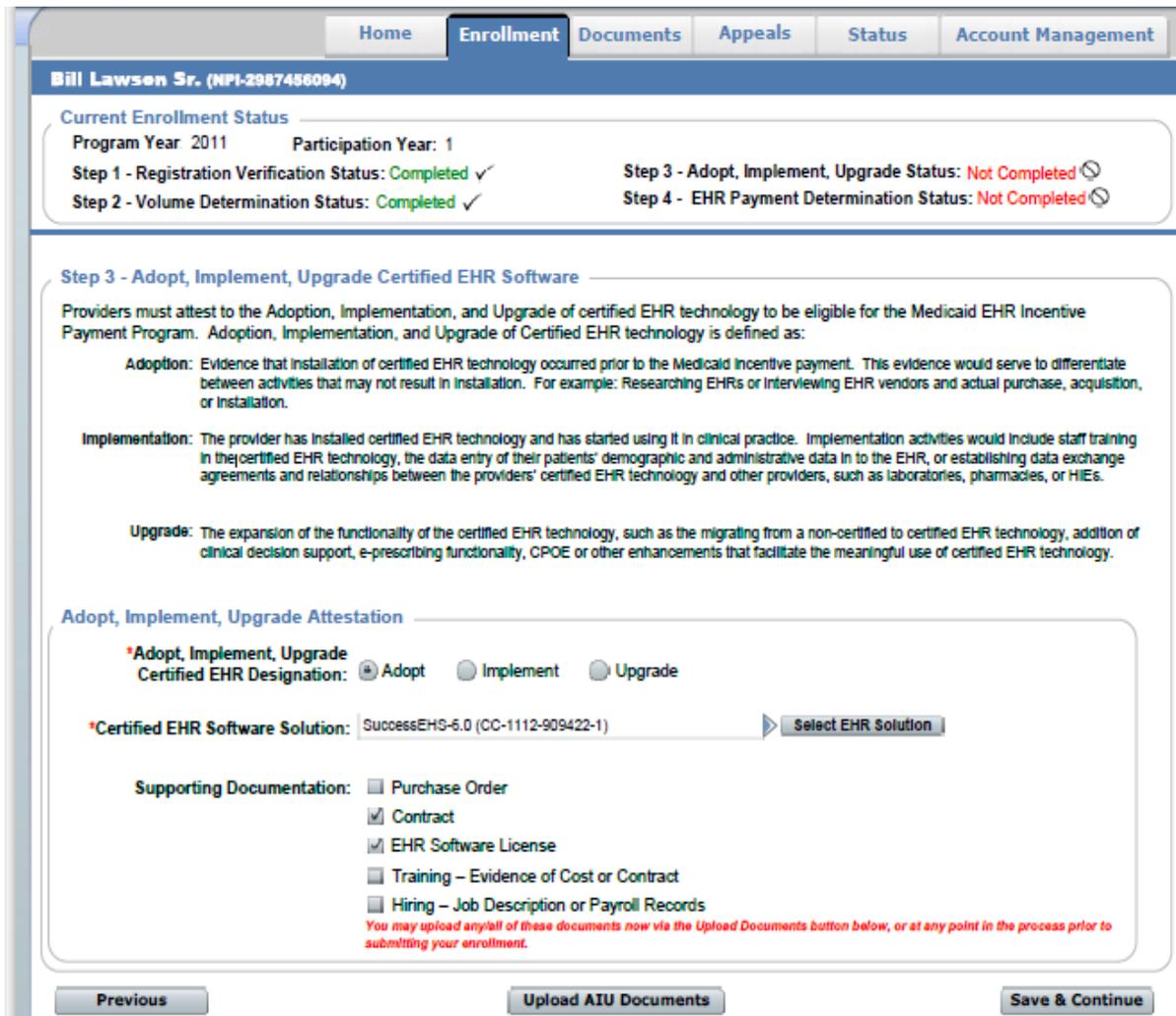
In addition to the online attestation, Medicaid Incentive360 is able to accept the CMS NLR C-5 transaction that confirms the dually eligible hospitals' compliance with the Medicare Meaningful Use criteria, thereby deeming them compliant in the Medicaid EHR Incentive Program.

Adopt, Implement or Upgrade

Medicaid Incentive360 guides program Year 1 participants, EHs and EPs, to enter data to support claim of Adoption, Implementation, or Upgrade (AIU) of EHR or in future years of Meaningful Use (MU). Supporting documentation must also be uploaded in order to complete their enrollment, as required per the state's SMHP policy.

As presented in Exhibit 4-11 representing the attestation requirement for a year 1 EP enrollment, Medicaid Incentive360 guides the provider through the identification of the ONC Certified EHR Software Solution that is being adopted, implemented or upgraded during the program year. Our solution also supports the secure upload of multiple tiers of supporting documentation to substantiate the provider claim, as configured to comply with the state's SMHP audit processes.

Exhibit 4-11: Sample AIU Attestation



The screenshot shows a web application interface for the AIU Attestation process. At the top, there are navigation tabs: Home, Enrollment (selected), Documents, Appeals, Status, and Account Management. Below the tabs, the user's name and NPI are displayed: Bill Lawson Sr. (NPI-2987456094). The main content area is titled "Current Enrollment Status" and shows the following information:

- Program Year: 2011, Participation Year: 1
- Step 1 - Registration Verification Status: Completed ✓
- Step 2 - Volume Determination Status: Completed ✓
- Step 3 - Adopt, Implement, Upgrade Status: Not Completed ✗
- Step 4 - EHR Payment Determination Status: Not Completed ✗

The "Step 3 - Adopt, Implement, Upgrade Certified EHR Software" section provides detailed instructions and definitions for Adoption, Implementation, and Upgrade. Below this, there is an "Adopt, Implement, Upgrade Attestation" section with the following options:

- *Adopt, Implement, Upgrade Certified EHR Designation: Adopt Implement Upgrade
- *Certified EHR Software Solution: SuccessEHS-6.0 (CC-1112-909422-1) [Select EHR Solution]
- Supporting Documentation: Purchase Order, Contract, EHR Software License, Training – Evidence of Cost or Contract, Hiring – Job Description or Payroll Records

A red note at the bottom of the supporting documentation section states: "You may upload any/all of these documents now via the Upload Documents button below, or at any point in the process prior to submitting your enrollment." At the bottom of the page, there are three buttons: Previous, Upload AIU Documents, and Save & Continue.

Stage 1 Meaningful Use

In addition to the solution currently in production use by CGI's client states, we have been in the process of design, develop, and implementation the functionality to support portal-based Meaningful Use attestation and collection of clinical quality measures as described by CMS Stage 1 of the EHR Incentive Program. This system function will also be included in the solution being proposed to Iowa at no additional cost. Modeled after the Medicare EHR Incentive Program Meaningful Use attestation portal developed by CGI for CMS, CGI has already completed the design of the Medicaid Incentive360 Meaningful Use attestation portal (including the collection of clinical quality measures) and has completed an initial Proof-of-Concept available for live demonstration. IME should not underestimate the effort required to design and develop the Meaningful Use attestation and collection of clinical quality measures functionality. Per our initial design, we are contemplating adding more than 80 new web pages to meet this next release's requirements. We are currently planning for the EH version of this functionality to be available to both Texas and Ohio providers no later than January 1, 2012, the first day that providers



can participate in Stage 1 Meaningful Use. EP Stage 1 Meaningful Use functionality will be deployed by April 1, 2012, the first point in time they can meet the minimum 90 day period during the payment year.

As required the system will recognize when a provider was enrolling for Program Year 2 of the EHR Incentive Program and direct them to the appropriate Meaningful Use and Clinical Quality Measure pages. The pages are organized into summary pages as shown in Exhibit 4-12 where the provider can select which measures they will report on (when a choice is allowed) and which ones they will defer. Based on their selection on the summary page, the system brings up only the corresponding detailed pages in which the provider can enter their data. Much like standard "wizard" functionality, the system effortlessly guides the provider through the entire process. Similar to other parts of the system, there are multiple opportunities for the provider to upload supporting data or the provider can elect to upload supporting data prior to final submission.



Exhibit 4-12: Meaningful Use - Menu Measures Page

Medicaid Incentive

360

[YourState.com](#) :: [CMS.GOV](#) :: [Help](#) :: [FAQ](#)

Medicaid EHR Incentive Program

Logout

Home
Enrollment
Documents
Appeals
Status
Account Management

Jacob Jones Sr. (EIN 11-7390237)

Meaningful Use – Menu Measures (1 of 14)

Hospital: Lancemer Hospital (CCN 7239054637)
Program Year: 2012
Participation Year: 2

The eligible hospital must submit a total of five Meaningful Use Menu Measures even if an Exclusion applies to all five. Please select at least five Meaningful Use Menu Measures from the list below. The ability to be excluded from a Meaningful Use Menu Measure is provided on the pages that follow. The eligible hospital may defer five Meaningful Use Menu Measures from the attestation compliance determination. Please make a selection from the Submit or Defer columns below as applicable.

You must submit at least one Meaningful Use Menu measure from the list below unless an Exclusion applies to all three:

Submit	Defer	Objective
<input type="radio"/>	<input checked="" type="radio"/>	Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.
<input checked="" type="radio"/>	<input type="radio"/>	Capability to submit electronic data on reportable (as required by State or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice.
<input type="radio"/>	<input checked="" type="radio"/>	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.

You must submit at least four Meaningful Use Menu measures from the list below unless an Exclusion applies to all four:

Submit	Defer	Objective
<input checked="" type="radio"/>	<input type="radio"/>	Implemented drug-formulary checks.
<input checked="" type="radio"/>	<input type="radio"/>	Record advance directives for patients 65 years old or older
<input checked="" type="radio"/>	<input type="radio"/>	Incorporate clinical lab-test results into certified EHR as structured data.
<input checked="" type="radio"/>	<input type="radio"/>	Generate lists of patients by specific conditions to use for quality improvements, reduction of disparities, research, or outreach.
<input type="radio"/>	<input checked="" type="radio"/>	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.
<input type="radio"/>	<input checked="" type="radio"/>	The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.
<input type="radio"/>	<input checked="" type="radio"/>	The eligible hospital or CAH that transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral.

Previous
Save & Continue



Although data is collected and confirmed at each step in the process, the Provider attestation occurs at a single distinct point in the enrollment process with a tailored state approved legal statement to provide a "digital" confirmation of the provider commitment to the validity of the enrollment.

Following an attestation, Medicaid Incentive360 preserves the "digital signature" as proof of the action. All data that a provider has attested to is stored in the repository for use in verifications, calculations, audits, disputes, payment processing, and reports. This data is stored in a read-only format to protect against repudiation.

The example Attestation, shown in Exhibit 4-13 commits the provider to the validity of the enrollment they have entered.



Exhibit 4-13: Enrollment Status - Final Attestation

e. Permit attestation for Adoption, Implementation or Upgrade to certified EHR products

Medicaid Incentive360 maintains cognizance of the program year for the participating provider at all times to direct the navigation to the appropriate enrollment and attestation pages. Per the CMS Final Rule regulations, the requirement for program year 1 for both EPs and EHS is Adoption, Implementation or Upgrade to an ONC certified EHR product.

A core function of the Medicaid Incentive360 is to support the program year 1 attestation requirement of adoption, implementation, or upgrade to certified EHR products. Participants enter their EHR Solution ID, also referred to as the Meaningful Use ID (MUID), into the AIU page of the portal to substantiate their claim of Adoption, Implementation, or Upgrade (AIU) of an EHR. The MUID is validated using a real-time web-service interface with ONC to confirm that the EHR has been certified as meeting the EHR Incentive Program requirements. In addition, Medicaid Incentive360 is configurable to support state discretionary requirements for the upload of supporting documentation in accordance with the state's approved SMHP policy. If the requirement is not met, they will be determined to be ineligible and will be required to either upload the documentation as required, or will be in a state of suspense, unable to proceed to receiving a program payment.

Medicaid Incentive360 guides program Year 1 participants, EHS and EPs, to enter data to support claim of Adoption, Implementation, or Upgrade (AIU) of EHR or in future years of Meaningful Use (MU). Supporting documentation must also be uploaded in order to complete their enrollment, as required per the state's SMHP policy.

As presented, the Exhibit 4-14 page layout represents the attestation requirement for a program year 1 EP enrollment, Medicaid Incentive360 guides the provider through the identification of the ONC Certified EHR Software Solution that is being adopted, implemented or upgraded during the program year. Our solution also supports the secure upload of multiple tiers of supporting documentation to substantiate the provider claim, as configured to comply with the state's SMHP audit processes.

Exhibit 4-14: Sample AIU Attestation



Home **Enrollment** Documents Appeals Status Account Management

Bill Lawson Sr. (NPI-2987456094)

Current Enrollment Status

Program Year: 2011 Participation Year: 1

Step 1 - Registration Verification Status: **Completed** ✓

Step 2 - Volume Determination Status: **Completed** ✓

Step 3 - Adopt, Implement, Upgrade Status: **Not Completed** ⊗

Step 4 - EHR Payment Determination Status: **Not Completed** ⊗

Step 3 - Adopt, Implement, Upgrade Certified EHR Software

Providers must attest to the Adoption, Implementation, and Upgrade of certified EHR technology to be eligible for the Medicaid EHR Incentive Payment Program. Adoption, Implementation, and Upgrade of Certified EHR technology is defined as:

Adoption: Evidence that installation of certified EHR technology occurred prior to the Medicaid Incentive payment. This evidence would serve to differentiate between activities that may not result in installation. For example: Researching EHRs or interviewing EHR vendors and actual purchase, acquisition, or installation.

Implementation: The provider has installed certified EHR technology and has started using it in clinical practice. Implementation activities would include staff training in the certified EHR technology, the data entry of their patients' demographic and administrative data in to the EHR, or establishing data exchange agreements and relationships between the providers' certified EHR technology and other providers, such as laboratories, pharmacies, or HIEs.

Upgrade: The expansion of the functionality of the certified EHR technology, such as the migrating from a non-certified to certified EHR technology, addition of clinical decision support, e-prescribing functionality, CPOE or other enhancements that facilitate the meaningful use of certified EHR technology.

Adopt, Implement, Upgrade Attestation

*Adopt, Implement, Upgrade Certified EHR Designation: Adopt Implement Upgrade

*Certified EHR Software Solution: SuccessEHS-6.0 (CC-1112-909422-1)

Supporting Documentation:

- Purchase Order
- Contract
- EHR Software License
- Training – Evidence of Cost or Contract
- Hiring – Job Description or Payroll Records

You may upload any/all of these documents now via the Upload Documents button below, or at any point in the process prior to submitting your enrollment.

Our widget driven approach has proven to be highly intuitive, as evidenced by the high participation volumes of our client states and low volume of calls, less than 1% of users, requesting guidance on how to use the system to process the enrollment.

f. Permit attestation for meaningful use.

CGI's Medicaid Incentive360 is on the forefront of Medicaid EHR Incentive Program solutions in the design, development and implementation of the Stage 1 Meaningful Use attestation functionality. As of submission time of submission of this proposal, CGI has submitted the proposed design for the Stage 1 Meaningful Use functionality to CMS for review and comment for the states of Texas and Ohio.

Reflecting the distinct differences in the program years between EPs and EHs, CGI has committed to implement the EH Stage 1 Meaningful Use attestation capability on January 1, 2012, the first day that EHs can meet the requirement of demonstrating 90 days of continuous use within the payment year. Likewise, the EP Stage 1 Meaningful Use attestation functionality will be deployed on April 1, 2012,

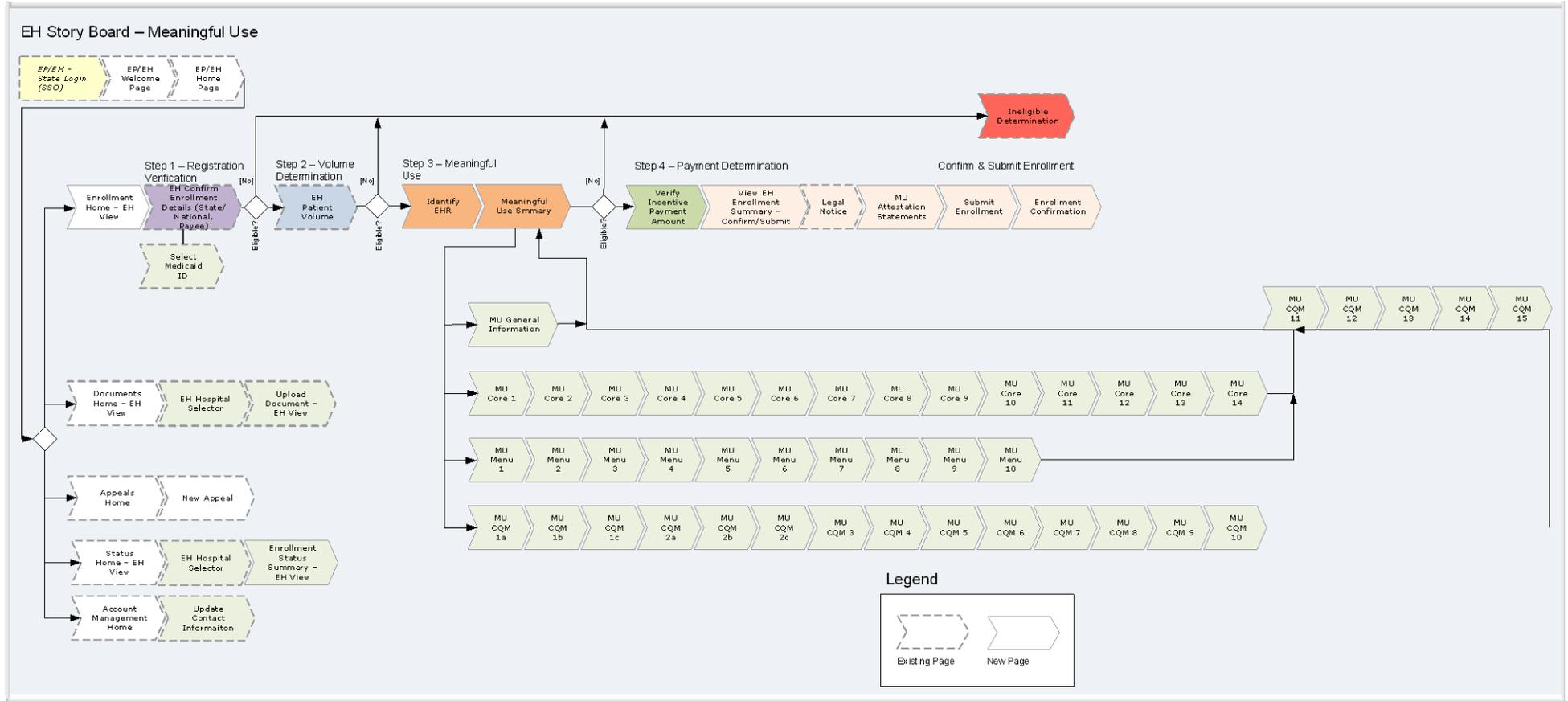
essentially the first day that EPs can meet their requirement of demonstrating 90 consecutive days of meaningful use during the payment year.

The Medicaid Incentive360 system maintains a configurable repository of the Medicaid meaningful use objectives and their associated measures, Clinical Quality Measures (CQMs) and supporting compliance data sent from the Enrollment Module. A Medicaid Eligible Hospital or Eligible Professional must be a meaningful EHR user for the relevant EHR reporting period in order to qualify for the EHR incentive payment program for a payment year. For payment year 2 the Eligible Hospital (EH) is required to identify a relevant 90-day EHR reporting period during the Federal Fiscal Year (FFY) of enrollment. For payment year 3 and beyond the Eligible Hospitals (EHs) are required to demonstrate a full year EHR reporting period aligned to the FFY of enrollment.

The MI360 system will calculate the percentage of compliance where required for a specific objective and its measure and will compare the calculation to the goal of that specific objective and its measure. In addition, the MI360 will determine whether an EH meets all the objectives of meaningful use of EHR technology. EHs deemed to comply with Medicaid attestation requirements by complying with the Medicare requirements will be reported by the NLR to the Medicaid state via the CMS NLR B-6 and C-5 interfaces.

Medicaid Incentive360 has emulated the style implemented for the CMS Medicare Meaningful Use Attestation system, also developed by CGI. Emulation of this user friendly, intuitive approach simplifies the provider experience and reduces the level of effort required by the IME help resources while maximizing righteous program participation. Exhibit 4-15 presents the story board for the 44 pages required to capture the Stage 1 Meaningful Use core measures and clinical quality measures.

Exhibit 4-15: EH Stage 1 Meaningful Use Story Board



In addition to the preceding EH Stage 1 Meaningful Use Attestation storyboard, we have included a sampling of the Meaningful Use data entry screens that present the adopted style and the ease of use features of our designs. Exhibit 4-16 provides the initial Meaningful Use page where the EH selects the Admission Method as well as the desired 90 day reporting period.

Exhibit 4-16: EH MU Attestation Method and Period

The screenshot displays the 'EHR Meaningful Use Information' page for Lancemer Hospital (EIN *****0237). The page is titled 'EHR Meaningful Use General Information Attestation' and contains the following sections:

- Emergency Department (ED) Admissions Method:** An Eligible Hospital (EH) must choose one of two methods to designate how patients admitted to the Emergency Department (ED) will be included in the denominator of certain Meaningful Use Core and Menu Measures. Please select the methods that will be used for ALL Meaningful Use Core and Menu Measures:
 - *ED Admissions Method:
 - Observation Service Method
 - All ED Visits Method
- EHR Meaningful Use Reporting Period:** Click the calendar icon to select your EHR Reporting Period Start Date. Meaningful Use year 1 requires a 90-day reporting period. Further reporting years require a 365 (366) day reporting period.
 - Meaningful Use Stage: 1
 - *EHR Reporting Period Start Date: 10/07/2011
 - EHR Reporting Period End Date: 01/05/2012

At the bottom of the page, there are buttons for 'MU Summary' and 'Save & Return'. A security logo for 'SECURE network solutions' is also present.

The following screen print, Exhibit 4-17, the user will begin the Meaningful Use Core Measures attestation questionnaire with this page. The user is required to select a Patient Record method and to enter the numerator and denominator.

Exhibit 4-17: Core Measures Questionnaire

CGI Medicaid Incentive 360 Help :: FAQ

Medicaid EHR Incentive Program Logout

Home Enrollment Documents Appeals Status Account Management

Lancemer Hospital (EIN *****0237)

Meaningful Use Core Measures

Core Measures Questionnaire (1 of 14) - MUCH001

(*) Red asterisk indicates a required field.

Objective

Use Computerized Provider Order Entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

Measure

More than 30% of all unique patients with at least one medication in their medication list admitted to the Eligible Hospital's (EH) inpatient or emergency department (POS 21 or 23) have at least one medication order entered using Computerized Provider Order Entry (CPOE).

Attestation

*Patient Records: Select whether data was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.

This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

Numerator: Number of patients in the denominator that have at least one medication order entered using Computerized Provider Order Entry (CPOE).

Denominator: Number of unique patients with at least one medication in their medication list seen by the Eligible Hospital (EH) during the EHR reporting period.

*Numerator: 500 *Denominator: 550

Target: 30.00% Actual: 90.90%

Result: Passed

Select the Previous Page or MU Summary buttons to go back without saving. Select the Save & Return or Save & Continue buttons to save & proceed.

Previous Page MU Summary Save & Return Save & Continue

NS SECURE network solutions

The final screen print sample presents a sample screen for the entry of a Clinical Quality Measure. In this example, Exhibit 4-18, the user is required to enter the numerator and denominator for this measure. After entering the numerator and denominator, Medicaid Incentive360 analyzes the data against the program requirements and provides an immediate indication of whether the measure has been met or not. This immediate feedback makes it much easier for the provider to remediate errors as they are entered, before proceeding and losing context.

Exhibit 4-18: Meaningful Use CQM Questionnaire Sample

The screenshot shows the Medicaid Incentive 360 web application interface. At the top, there is a navigation bar with the CGI logo, 'Medicaid Incentive 360', and 'Medicaid EHR Incentive Program'. Below this is a secondary navigation bar with buttons for 'Home', 'Enrollment', 'Documents', 'Appeals', 'Status', and 'Account Management'. The main content area is titled 'Lancemer Hospital (EIN *****0237)' and 'Meaningful Use Clinical Quality Measures (CQMs)'. The specific questionnaire is 'CQM Questionnaire (1 of 19) – NQF 0495/ED-1.3'. A note states: '(*) Red asterisk indicates a required field.' The form has three sections: 'Title' (Emergency Department Throughput), 'Description' (ED patients with a principal Dx of Psychiatric or mental health disorder- median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the ED.), and 'Attestation'. The 'Attestation' section asks to complete the following information: 'Denominator: ED patients with a Dx of Psychiatric/Mental Health admitted to the facility from the ED.' and 'Numerator: Median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the ED.' Below this, there are input fields: '*Denominator: 100' and '*Numerator: 99'. The 'Result' is shown as 'Entered'. At the bottom of the form, there are instructions: 'Select the Previous Page or MU Summary buttons to go back without saving. Select the Save & Return or Save & Continue buttons to save & proceed.' and four buttons: 'Previous Page', 'MU Summary', 'Save & Return', and 'Save & Continue'. A 'SECURE' logo is visible in the bottom right corner.

g. Have the ability to deem a hospital as meeting meaningful use for Medicare.

In accordance with the EHR Incentive Program Final Rule, Medicaid Incentive360 provides the ability to deem an Eligible Hospital’s Meaningful Use compliance based on the receipt of appropriate CMS National Level Repository interface transactions that:

- ▶ Identify the EH as Dually Eligible (B-6 Registration Transaction)
- ▶ Receipt of Medicare Meaningful Use compliance criteria (C-5 Dually Eligible Hospital MU Criteria)

Upon receipt of a validated C-5 Dually Eligible Hospital Attestation Data interface transaction from CMS, the MU criteria and CQM measures are parsed and stored in the Medicaid Incentive360 state database and the provider is deemed to have met Stage 1 Meaningful Use criteria.

The eligibility of the hospital will be confirmed against the local MMIS data as well as the CMS data prior to processing the payment.

h. Provide a hospital calculator to determine EHR incentive payment amounts.

Medicaid Incentive360 applies all payment calculations in accordance with the latest algorithms approved and published by CMS. In addition, in the event of a subsequent revision to payment calculation methodologies by CMS, Medicaid Incentive360 includes a Payment Adjustment capability that allows the state to retroactively apply calculation modifications and identify the impact of the revised calculation method.

We work with the individual states to determine the actions that are desired for over-payments and underpayment situations triggered by the revisions. Medicaid Incentive360 has the ability to hold the discrepancy amount to apply to the next year's payment or to either issue a supplemental payment or payment request as appropriate.

The following is an overview of the hospital payment calculation process currently applied by Medicaid Incentive360, as approved in the Final Rule, CMS documented standards and formula for calculating eligible hospital payments.

- ▶ The Hospital Calculation is a one-time calculation of a total incentive payment
- ▶ MI360 allows a State to configure the payment distribution over a 3 to 6 year period.
 - The calculation is broken into two components as defined in the CMS Medicaid Hospital Incentive Payments Calculations rules published document :
- ▶ Overall EHR Amount
- ▶ Based on the Hospital's total number of inpatient acute care discharges over a theoretical 4 year period
- ▶ Medicaid Share
 - Numerator
 - Estimated Number of Medicaid Acute Care Inpatient Days +
 - Estimated Number of Medicaid Managed Care Acute Inpatient Days
 - Denominator
 - Estimated Number of Acute Care Inpatient Days *
- ▶ The Non Charity Percentage
 - Numerator
 - The estimated total amount of the eligible hospital's charges during that period, not including any charges that are attributable to charity care
 - Denominator
 - The estimated total amount of the hospital's charges during that period
- ▶ Medicaid Aggregate EHR Amount
 - Overall EHR Amount multiplied by Medicaid Share
- ▶ Medicaid Aggregate EHR Amount is then disbursed over multiple years (no less than three, no more than 6) as defined in the State Health Information Technology Plan. Noting, the payment percentage and timeframe are used to define the MI360 configurable payment schedule. Year 1 payment cannot exceed 50%, and years 1 and 2 cannot exceed 90%.

Hospital Data entered as part of the Payment Calculation is audited based on Hospital Cost Reports. In most States, hospitals enrollments are flagged for Desk Audit due to the payment amounts and the potential complexity in validating eligibility. We will work with the State of Iowa during the requirements validation phase of the project to confirm the preferred business rules and approach. Exhibit 4-19 presents the overview page for the hospital payment calculation describing the calculation algorithm for a state that has elected a three year payment cycle with 50%, 40% and 10% per year, respectively.

Exhibit 4-19: Hospital Payment Calculation Help

Home | **Enrollment** | Documents | Appeals | Status | Account Management

Jacob Jones Sr. (EIN 11-7390237)

Current Enrollment Status

Hospital: Lancemer Hospital (CCN 7239054637) Program Year: 2011 Participation Year: 1

Step 1 - Registration Verification Status: **Completed** ✓ Step 3 - Adopt, Implement, Upgrade Status: **Completed** ✓

Step 2 - Volume Determination Status: **Completed** ✓ Step 4 - EHR Payment Determination Status: **Not Completed** ⚠

Step 4 – EHR Payment Determination Introduction

EHR Payment determination is an automated process based on your inputs. To begin the calculation of your EHR Incentive payment you will be required to provide details for your participation in the Medicaid Program. The aggregate EHR incentive amount is based on a four year program model. Your aggregate EHR incentive payment will be distributed on the following payment schedule:

- Year 1 – 50%
- Year 2 – 40%
- Year 3 – 10%

Aggregate EHR Incentive Payment Calculation

The Base Amount of your EHR Incentive payment is calculated as the product of two factors:

1. Overall EHR Amount:

Sum of:

- Year 1 – (Base Amount of \$2,000,000.00 + (Number of Discharges [1150 – 23,000] * \$200.00) * Transition Factor (1.00)
- Year 2 – (Base Amount of \$2,000,000.00 + (Number of Discharges [Year 1 Discharge * Annual Growth Rate] * \$200.00) * Transition Factor (.75)
- Year 3 – (Base Amount of \$2,000,000.00 + (Number of Discharges [Year 2 Discharge * Annual Growth Rate] * \$200.00) * Transition Factor (.50)
- Year 4 – (Base Amount of \$2,000,000.00 + (Number of Discharges [Year 3 Discharge * Annual Growth Rate] * \$200.00) * Transition Factor (.25)

2. Medicaid Share:

Sum of:

- Estimated number of Medicaid inpatient-bed-days
- Estimated number of Medicaid managed care inpatient-bed-days

Divided by the product of:

- Estimated total number of inpatient-bed-days during the period
- Estimated total amount of charges during that period, not including any charges that are attributable to charity care, divided by the estimated total charges during the period

3. Aggregate EHR Incentive Amount = Overall EHR Amount * Medicaid Share

Calculation Example

Previous **Save & Continue**

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In addition to the information provided in the preceding page, we provide a detailed example using the state-specific payment terms as presented in Exhibit 4-20 if the user selects “Calculation Example”.

Exhibit 4-20: Medicaid Incentive360 EH Payment Calculation Example

Hospital EHR Incentive Calculation Example

Hospital A, an acute care hospital, meets the Medicaid patient volume threshold, becomes a meaningful user of certified EHR technology, and is eligible for incentive payments beginning in FY 2011. Hospital A had 2,000 discharges in FY 2010. Assume that for the four-year period of participation Hospital A had 5,000 Medicaid inpatient-bed-days and 2,000 Medicaid managed care inpatient-bed-days. Its total inpatient-bed-days in FY 2010 were 21,000. Hospital A's total charges excluding charity care were \$8,700,000, and its total charges for the period were \$10,000,000. The annual growth data for the last three years of available data are:

FY 2007 — 1,558 discharges – for a 22.1% annual growth rate
FY 2006 — 1,158 discharges – for a 25.7% annual growth rate
FY 2005 — 970 discharges – for a 16.2% annual growth rate

This means that the average annual growth rate that will be applied to the subsequent three years is 21.33%. Based on this information, Hospital A's aggregate EHR amount would be \$2,169,576.97. It was calculated as follows:

Initial Amount (with annual growth rate factored in to the number of discharges) * Transition Factor
Year 1—\$2,170,200.00 = {\$ 2,000,000 + [(2,000 – 1,149) * \$200]} * 1.00
Year 2—\$1,691,658.83 = {\$ 2,000,000 + [(2,427 – 1,149) * \$200]} * 0.75
Year 3—\$1,179,549.84 = {\$ 2,000,000 + [(2,944 – 1,149) * \$200]} * 0.50
Year 4—\$ 621,187.23 = {\$ 2,000,000 + [(3,572 – 1,149) * \$200]} * 0.25

Overall EHR Amount = \$5,662,595.90

Medicaid Share – 0.38 = [(5,000 + 2,000) divided by [21,000 x (\$ 8,700,000/\$ 10,000,000)]]

Aggregate EHR Amount – \$ 5,662,595.90 x 0.38 = \$ 2,169,576.97

Payment Schedule:
Year 1 – 50% of Aggregate EHR Incentive Payment = \$1,084,788.49
Year 2 – 40% of Aggregate EHR Incentive Payment = \$ 867,830.79
Year 3 – 10% of Aggregate EHR Incentive Payment = \$ 216,957.70
Total Aggregate EHR Incentive Payment = \$2,169,576.97

Close

i. Allow the provider to upload supporting documentation.

MI360 includes a robust documentation repository that is accessible from both the Provider and Business Services portals. The Provider Portal allows program participants to upload relevant document at multiple points during the registration and attestation process while allowing the flexibility to defer uploads until the end of the attestation process, if desired. All documents are categorized and indexed by type and relevance to the enrollment as a configurable component of the solution.

MI360 accepts a variety of formats, such as MS Word, Excel, PowerPoint, PDF, TXT, RTF and others. Documents are stored and accessible through intuitive, easy to use user interfaces in both portals. At this juncture, there is no need for program participants to provide any information containing Protected Health

Information (PHI) as defined by HIPAA. As such, whenever uploading documents, the system prompts the user to confirm that the documents do not include any PHI. This warning/confirmation was implemented as the result of early system users uploading PHI laden documentation. Since the implementation of this confirmation step, we have not encountered any PHI in uploaded documents. This is an example of how we continually strive to refine the system to reflect real world experiences.

The CGI Medicaid Incentive360 team is trained on HIPAA policies and procedures on an annual basis. As such, detailed procedures are in place to govern the actions to be taken in the event PHI is encountered in uploaded documentation. These procedures are consistent with the responsibilities in accordance with the Business Use Agreement.

The following screen print, Exhibit 4-21 , presents the document upload dialog box and the PHI notice.

Exhibit 4-21: Sample Document Upload Dialog Box

The screenshot shows a web application interface for the Medicaid EHR Incentive Program. At the top, there is a navigation bar with the CGI logo, 'Medicaid Incentive 360' branding, and the URL 'MI360.ORG :: CMS.GOV :: Help :: FAQ'. The main header reads 'Medicaid EHR Incentive Program' with a 'Logout' link. Below this is a menu with options: Home, Enrollment, Documents (selected), Appeals, Status, and Account Management. The user's name 'Samantha Rae' is visible in the top left. The 'Documents' section is active, showing instructions for uploading documents. The 'Document Upload' dialog box is open, containing the following fields and instructions:

- Document Upload**
To upload a document, choose your document 'Category' and 'Type'. Then, click on 'Browse....' to locate and select your file. Once selected, click on 'Upload' to complete the upload.
- Acceptable File Formats:** Microsoft Word (DOC), Microsoft Excel (XLS), Microsoft Works Word Processing (WPS), WordPerfect Document (WPD), Rich Text Format (RTF), Tagged Image File (TIF,TIFF), Portable Document Format (PDF), Text (TXT), Microsoft PowerPoint (PPT).
- (*)Red asterisk indicates a required field.**
- *Program year:** 2011 (dropdown)
- *Category:** Patient Volume (dropdown)
- *Type:** EHR Patient Encounters (dropdown)
- *File:** [Empty text box] Browse...
- 60 Characters Max**
- *Document Description:** [Empty text box]
- Check this box to confirm that the documents you are uploading do not contain any Protected Health Information (PHI) as defined by HIPAA.
- Buttons: Upload, Cancel

At the bottom of the page, there is a footer with the URL 'www.cgi.com' and a 'SECURE network solutions' logo with a lock icon and the text 'DATA ENCRYPTED'.

Once a document has been uploaded, it cannot be deleted by the provider. All deletions must be requested through the Business Services Center under the strict policies and procedures governing production data modifications.

j. Provide information about application status.

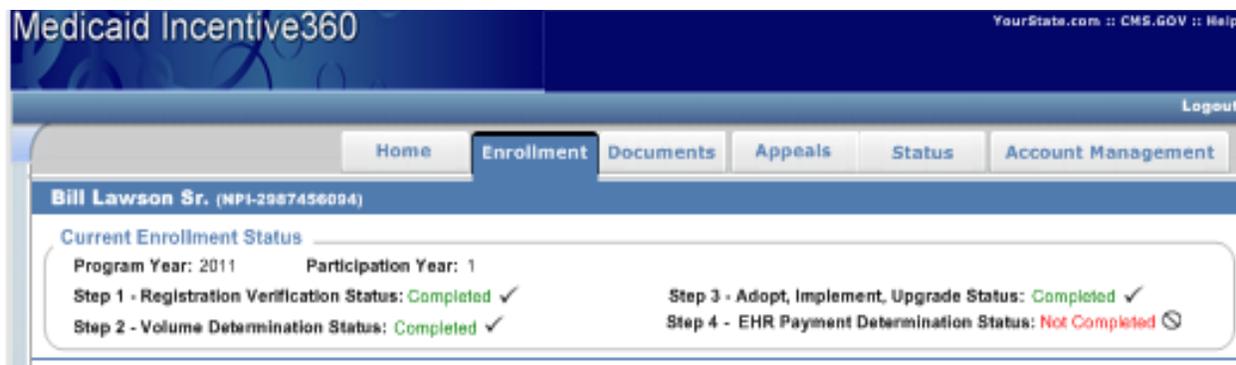
Medicaid Incentive360 provides the provider real-time enrollment status information as well as summary application status available by participation year at all times. The general nature of this program results in use of the system once per year, thereby making ease of use a high design priority. Our utilization of workflow driven widgets guides the providers in a progressive, logical sequence to facilitate intuitive flow and minimize the need for call center assistance. The use of a standard page style guide that includes the status of where they are in respect to completing the enrollment, as well as providing the provider name and NPI has proven to be an effective design mechanism.

In addition to the persistence of the current enrollment status throughout the process, we also provide an online status page for the provider to track the status of the payment process after the successful completion of the enrolment and subsequent attestation. The provider can access the system at any time to monitor the status of all program year enrolments

The following screen print samples illustrate how the Medicaid Incentive360 system provides the provider constant context of where they are in the current enrolment process and how much is left to be completed. This is important to communicate the level of progress and establish expectations regarding the number and sequence of remaining steps.

Exhibit 4-22 provides a visual summary of a provider's status and gives the providers clear indicator of where they are in the process.

Exhibit 4-22: Enrollment Status



The previous screen shot sample presents our approach to providing status and context for the current enrollment. The next screenshot, Exhibit 4-23, presents a sample Status page for an Eligible Professional program history. By selecting any of the existing enrollments, the provider can review the details and status of each.

Exhibit 4-23: Example Status Page for Eligible Professional

Medicaid Incentive360 YearState.com :: CMS.GOV :: Help

Logout

[Home](#)
[Enrollment](#)
[Documents](#)
[Appeals](#)
[Status](#)
[Account Management](#)

Bill Lawson Sr. (NPI-2987458094)

Medicaid EHR Incentive Payment Plan Status Summary
 The following sections outline the current and historical events for your enrollment in the Medicaid EHR Incentive Payment Program.

Enrollment Summary

National Provider Information

Name: Billy Lawson Sr.
Provider Type: Physician-MD
Provider Specialty: Physician-DO, Oncologist
Business Address: 287 Rangle Drive, Suite 2
 San Antonio, TX 78254-9087
Phone #: (512) 619-6468 Ext:3456
Tax ID: xxx-xx-6743 (SSN)
NPI: 2987458094
CMS Confirmation #: 5923710625

State Provider Information

Enrollment ID: 1928472
MMIS Provider ID: 845298854
MMIS Provider Status: Active
Hospital Based: No
State Licensed: Yes
Enrolled Medicaid Provider: Yes
Hospital Based Percentage: 15%
Works in FQHC or RHC: No
Affiliated FQHC or RHC: N/A
Alternate Phone Number: (703) 481-3278 Ext: 6734
Email Address: Bill.Lawson@DHClinics.com

Group Practice

Payee TIN: 11-7643214 (EN)
Payee NPI: 8210587129

k. Issue electronic notices of denial, with information on how the provider may re-apply.

Medicaid Incentive360 features a robust communications engine that provides the ability to issue a variety of state configured automated communications that are triggered by a series of program events, including eligibility denial. Our highly flexible, communications engine allows the states to identify specific program-based events which should trigger communications to the providers, as well as other relevant stakeholders, such as the state program administrators.

The ineligibility communication includes details regarding the nature of the ineligibility determination as well as instructions regarding how to appeal or refine the enrollment.

In addition to program denials/ineligibility, Medicaid Incentive360 has a robust set of standard email communications and notifications that can be triggered throughout the program lifecycle as events necessitate. These messages are designed to provide up-to-date status information to the program participants through all phases of the process, including instructions on how to proceed to the next step of the process. We have developed a consistent framework and format to the messaging component to make it easier to add new messages as needed. Many messages will be system generated based on triggers that are configured based on the verified requirements of Iowa as determined during the Requirements Validation activities.

Medicaid Incentive360's Event Broker plays an important role. The Event Broker can be configured and allows messages to be distributed based on conditions that are setup using this table-driven mechanism. In addition, email messaging will allow program staff to communicate with groups of participants through the Event Broker (such as a broadcast message about system upgrades or downtime, etc.) when needed. Exhibit 4-24 presents the current set of standard email messages configured in Medicaid Incentive360 at the time of submission of this response. For ease of communication with the Business Services team, we prefix all messages with a two character code since many messages have similar names but have different usages.

Exhibit 4-24: Medicaid Incentive360 Standard Email Messages

Message Name/Description	Medicaid Incentive360 Requirement
C1-NOT-FOUND	No crosswalk to match b6
C2-WELCOME	Provider is able to enroll
C3-ACCT-UPD	User has updated account information
C4-CONFIRM-ENROLL	Provider has confirmed enrollment
C5-APPEAL-INITIATED	The provider has initiated an appeal
C6-APPEAL-RESOLVED	The appeal has been resolved.
C7-INELIGIBLE-ENROLL	The provider is ineligible - enrollment
C8-INELIGIBLE-AUDIT	The provider is ineligible - desk audit.
C9-APPEAL-ESCALATED	The provider has escalated the appeal.
C10-NLR-UPDATE	A B6 update transaction has been received.
C11-NLR-CANCEL	A B6 cancel transaction has been received.
C12-MMIS-PDC	MMIS Payment Denial Check
C13-PDC2-New-Payee-Reqd	The provider has failed PDC2
C14-StatePDC-New-Payee-Reqd	The provider has failed PDC during state payment
C15-Return-In-Progress	The provider's status has been set to In-Progress by BSC
C16-RESPONSE-D16	The provider has failed D16

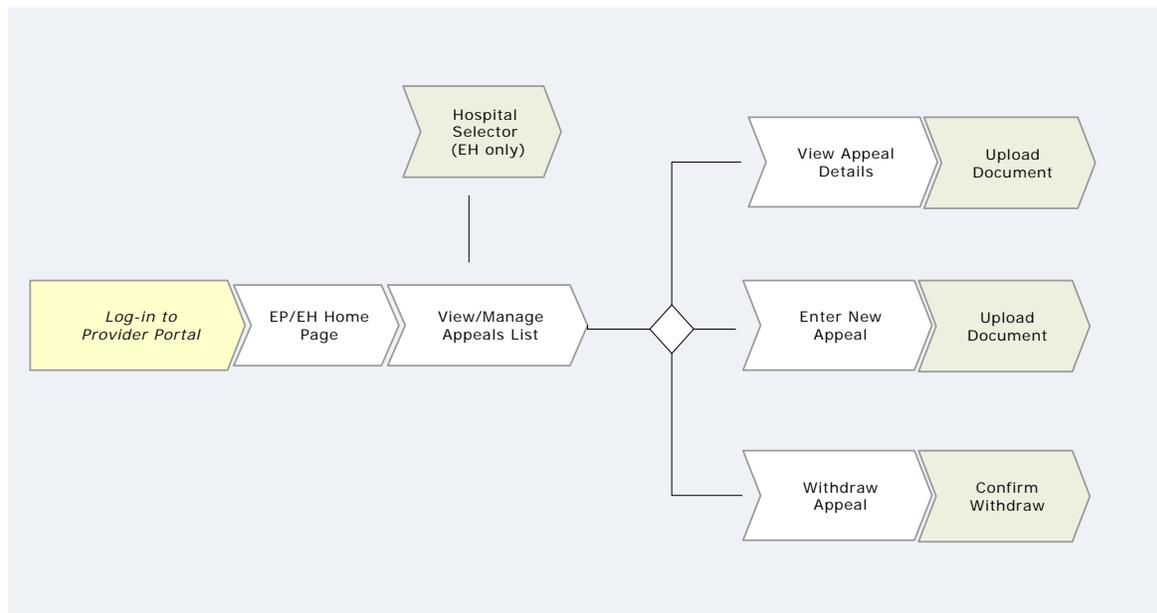
Message Name/Description	Medicaid Incentive360 Requirement
C17-PAYMENT-DISBURSED	Notify user of payment disbursal
C18-D16ERROR-RESPONSE	Notification of D16 Error
C19-Invalid-Provider-Type.	The provider type is invalid for the EHR Program
State-STARTUP	State Start-up Mass Mailing to invite providers
U1-Password-Notification	Notify user of single use password
U2-Update-Password	Notify user of password update

I. Provide information to the provider of how to file an appeal with the Agency.

Medicaid Incentive360 provides an intuitive process for providers to file an appeal with the Agency. Exhibit 4-25 presents a user's perspective on the Appeals process. A provider can initiate an inquiry to the Medicaid EHR Incentive Program administrators about the outcome of a decision at any point in the enrollment, attestation or payment processes. The inquiry, in the form of an Appeal, is logged into the system and triggers the Appeal workflow as defined, configured and implemented for the state. An initial Appeal, also called a first level Appeal, is typically reviewed and adjudicated by the EHR Incentive Program administrative operations in accordance with the established policies and procedures. If the Appeal is denied or dismissed, the program participant can request that the appeal be escalated to be considered by the IME administrative staff for re-consideration. Medicaid Incentive360 will acknowledge receipt of an appeal and start the appeals workflow process. Staff can view provider information and request supporting documentation to adjudicate or resolve the appeal. Appeal management privileges can be configured and allocated to ensure that there is a separation of responsibilities between the first level appeals and escalated appeals.

At all times during the process, the provider can view the status of the appeal. Should the state's program administration staff establish the provider's eligibility, the status is updated and the NLR is informed of the change via a revised B-7 update transaction. If the provider remains ineligible, then a notification of the determination is sent via email.

Exhibit 4-25: Dispute and Appeals Processes



The following are the standard steps in the Appeals processes:

- ▶ Appeals are initiated by a program participant using the Medicaid Incentive360's Provider Portal Appeals page. A short description and supporting documentation may be added.
- ▶ Medicaid Incentive360 generates an automated email acknowledgement to the provider acknowledging receipt of appeal
- ▶ Appeal case is queued in the Business Services Portal for analyst to review
- ▶ Additional sub classification such Eligibility, Payments, Payment amount, demonstration of AIU, program exclusion, etc. can be added if required
- ▶ Cases are researched by program administration staff, reviewed, and adjudicated
- ▶ Reports are available showing the number of Appeals cases received, resolved, and pending
- ▶ IME staff can follow-up on aging pending cases
- ▶ As cases are resolved, outcome decisions and documentation can be added to Medicaid Incentive360 to make a complete case history
- ▶ In cases where there is a change in status of eligibility, an adjustment of payment, or a determination of exclusion, Medicaid Incentive360 will construct the appropriately populated interface for submission to CMS via the NLR interfaces

Exhibit 4-26 displays the Medicaid Incentive360 page that is used by a provider to initiate an appeal. This allows uploading documentation necessary to support the appeal.

Exhibit 4-26: Creating a New Appeal

New Appeal

You can select your Enrollment ID, Category, Type and Program Year to begin the appeal process. You are also required to enter a brief description outlining your reason for the appeal. To upload a document for your appeal click the Upload Document button below, then click browse to select your file. Once selected, click the Upload button to complete your upload.

Please contact our service center at xxx-xxx-xxxx between the hours of 7AM-7PM MT if you have any questions or need assistance opening an appeal.

(*) Red asterisk indicates a required field.

*Enrollment ID:	1928472	Appeal ID:	
Name:	Bill Lawson	*Category:	Adopt, Implement, Upgrade
Business Address:	287 Rangle Drive, Suite 2 San Antonio, TX 39854-9087	*Type:	Contract
Phone #:	(512) 619-6498	*Program Year:	2011
Alt Phone #:		*Participation Year:	1
Tax ID:	xxx-xx-8743 (SSN)	Initiated Date:	01/01/2011
NPI:	2987458094		
TPI/API:	845298654		

*Appeal Description:

2000 Character Max

Upload Document

Submit Cancel

After the appeal is reviewed and adjudicated, information regarding the decision is annotated into the Medicaid Incentive360 Appeals case page and summary information is available as shown in Exhibit 4-27. This summary page can be viewed at anytime by Business Services and authorized state of Iowa IME administrative staff.

Exhibit 4-27: View Appeal Page

View Appeal

Appeal details are listed below. Click the "New Note" button to add a note to your appeal or "Cancel" to return to the Appeals home page.

Enrollment ID:	1928472	Appeal ID:	754926
Name:	Bill Lawson	Category:	Patient Volume
Business Address:	287 Rangle Drive, Suite 2 San Antonio, TX 39654-9087	Type:	Hospital Based
Phone #:	(512) 619-6498	Program Year:	2011
Alt Phone #:	(512) 619-6499	Participation Year:	1
Tax ID:	xxx-xx-6743 (SSN)	Initiated Date:	01/01/2011
NPI:	2987456094	Resolved Date:	01/02/2011
TPI/API:	845298654	Status:	Resolved

Appeal Description: I opened this appeal because I have more encounters that I can claim to be eligible for the program.

Appeal Comments

Name	Date/Time	Comment (3000 Character Max)
Craig Earls	01/01/2010 09:45:34AM	I called Mr. Lawson at his listed office number and requested that his receptionist give him a message to follow-up with us in regards to his eligibility determination. I requested that he upload supporting documentation.
Billy Lawson	01/01/2010 1:23:54PM	I uploaded the document for your review.
Craig Earls	01/02/2010 08:41:39AM	I have reviewed Mr. Lawson's uploaded document and it did show that he has additional Medicaid encounters. I have added these encounters and he now has met the 30% Medicaid Volume threshold. Issue resolved, marking appeal as such.

[New Comment](#) [Appeals Home](#)

m. Interface to the Certified Health IT Product list (ONC/CHPL) web service for certification verification.

Medicaid Incentive360 interfaces with the ONC CHPL website using their web-service to verify that the program participant's EHR software is on the Certified HIT Product List. This interface is currently in production for our existing client states.

The current interface verifies the specified EHR Software Solution has been certified as eligible by the ONC. There are upgrades being discussed to support the exchange of additional system details such as name, version and other relevant information. As this information becomes available through the ONC web-services, Medicaid Incentive360 will be enhanced to accept, store and display the information.

n. Verify the provider is an active provider with Medicaid.

Medicaid Incentive360 provides multi-dimensional capabilities to confirm status with Medicaid, including through local MMIS data as well as data sources. CGI recognizes that states reserve the prerogative whether or not to require program participants to be registered with the state's MMIS. Medicaid Incentive360 provides states the flexibility to designate the source of data for validation, as well

as determine the approach for provider status validation to fulfill the methods approved through the SMHP.

Medicaid Incentive360 is designed to leverage provider demographic, enrollment, claim summary and status data from the state MMIS, Data Warehouses and other sources, such as Regional Extension Centers (RECs) or Health Information Exchanges (HIEs) to facilitate the evaluation of the provider’s qualification to participate in the program in accordance with the requirements as presented in the Final Rule. Specifically, Medicaid Incentive360 is designed to consume the following data from the local state MMIS environment and other approved, trusted data sources:

- ▶ **Provider Demographics Data** – Used to validate the information provided on the NLR B-6 transactions and confirm that the provider is known and registered with the Iowa MMIS
- ▶ **Provider Groups** – Used to identify any group affiliations that a provider has
- ▶ **Claims Summary** – Summary of Medicaid claims by type and service location for the provider
- ▶ **State Sanctions Exclusions** – May be included in the Provider Demographic Data

While MMIS’s typically maintain detailed provider information for the Fee-For-Service providers, oftentimes, they do not have cognizance of the FQHC, RHC and Managed Care Organization providers. Current Medicaid Incentive360 clients have implemented different approaches and philosophies regarding verifying provider status for the providers that are not typically billing providers or included as rendering providers for Medicaid services. One state has decided to require that all participants register with the MMIS program to facilitate status management as well as payments, while other states have decided to require audits for all providers that are not recognized in the MMIS data. We look forward to working with the IME team to discuss the pros and cons to each of these approaches, as well as other derivatives, to determine the best approach for the State of Iowa.

For informational purposes, we provide sample file layouts representing the data that we receive and utilize from our current states for MMIS status validation. These are presented for information purposes and do NOT represent the required data.

Sample Provider Demographics Data File Layout

The following table, Exhibit 4-28, presents a sample layout of a Provider Demographic file layout. We will work with the State during the Requirements Validation sessions and develop the precise data file layouts required.

Exhibit 4-28: Sample Provider Demographics Extract Mapping

Extract File Field	Column in MI360_mmis_provider_demographics
Provider NPI	st_npi
Provider Tax ID	st_tin
Provider Medicare Number	st_ccn
Provider ID	st_mmis_id_provider
Provider Name	nm_provider

Provider Enroll 1 Code	st_active_cd
Provider Type Code	cd_provider_type
Provider Type	st_provider_type_descr
Provider Specialty Code	cd_provider_specialty
Provider Specialty	st_provider_specialty_descr
Provider Specialty Code 2	cd_provider_specialty_two
Provider Specialty 2	st_provider_specialty_two
Provider Address 1	st_addr1
Provider Address 2	st_addr2
Provider City	st_city
Provider State Code	st_state_abbr
Provider Zip Code	st_zip
Provider Phone Number	st_phone_number
<i>[timestamp of record creation]</i>	ts_cr

Sample Provider Claims Summary Data File Layout

The following table, Exhibit 4-29, presents a sample layout of an EP Provider Claim Summary file layout. We will work with the State to determine the requirements for Iowa during the Requirements Validation sessions, and develop the precise data file layouts required.

Exhibit 4-29: Sample EP Claim Summary File

Field Name	Type	Length	Column in MI360_mmis_provider_profile_ep_all
Provider NPI	Varchar	10	st_NPI
Payto Prov ID	Varchar	9	st_mmis_id_provider_grp
Provider ID	Varchar	9	st_mmis_id_provider
Service Year	Varchar	4	num_calendar_yr
Service Month	Varchar	6	st_month (converted as described above)
Visits Provider Prof	Varchar	6	cnt_visits_provider_prof
Visits Provider Fac	Varchar	6	cnt_visits_provider_facility
Place of Service	Char	2	

o. Provide help screens acceptable to the Agency.

Ease of use has been a primary design objective for CGI’s Medicaid Incentive360 since inception more than 15 months ago. It is recognized that this system will be used infrequently by the provider community, approximately once per year, thereby necessitating the use of descriptive user interfaces and industry standard design concepts. Our goal is for the program participant community to require the same amount of training as they required using eBay, Facebook, Amazon or any of the other mainstream web-based systems. To fulfill this goal, we have included detailed instructions for each step of the process to minimize the need to launch help facilities. We continue to enhance the system design to meet this objective based on feedback received by our Business Services Center staff.

First and foremost, Medicaid Incentive360 includes both policy and how-to information directly on the page at the point in the process where the information is relevant. For most Providers, this will be the right level of information for their needs. Additionally, Medicaid Incentive360 has both Help and FAQ documents for the system that are provided as links in the application. Medicaid Incentive360 also provides links to the CMS EHR Incentive Program website and each State’s Medicaid EHR Incentive Program website so that Providers can access additional information.

Lastly, Medicaid Incentive360 presents contact information, including email address and phone numbers, for Providers to use in the event they need additional support during their enrollment process. CGI is proud of the very positive feedback that we have received to date from Eligible Hospital program participants that have used other state systems, stating that our implementation in Texas was by far the easiest out of the 16 they have used to date.

During the Requirements Validation activities, we will work with IME to agree upon the user assistance collateral, including help screens, that meet the needs of the Agency.

4.1.2 ADMINISTRATIVE TOOLS AND SERVICES

2. Provide EHR program administration tools and services, which include but are not necessarily limited to:

a. Submitting e-mail notifications to providers with the information and requirements for eligibility upon receiving registration from the NLR.

Medicaid Incentive360 features a robust communications engine that provides the ability to issue a variety of state configured automated communications that are triggered by a series of program events, including acknowledgement of the receipt of the NLR B-6 registration transaction. When Medicaid Incentive360 receives a B-6 registration transaction, it triggers the validation of the provider's status using the local state provider crosswalk, typically utilizing MMIS data, validating the existence of the provider based on NPI and TIN. In addition to the provider crosswalk validation, we conduct the first of at least three Provider Denial Code (PDC) checks to verify that the provider is in good standing with the state Medicaid program. Depending on the results, Medicaid Incentive360 triggers a communication to the provider communicating the initial status results and providing directions on the next steps. The language included on these emails is configurable for each state to meet your unique needs and requirements.

Our highly flexible, communications engine allows the states to identify specific program-based events which should trigger communications to the providers, as well as other relevant stakeholders, such as the state program administrators.

The ineligibility communication includes details regarding the nature of the ineligibility determination as well as instructions regarding how to appeal or refine the enrollment.

In addition to program denials and ineligibility, Medicaid Incentive360 has a robust set of standard email communications and notifications that can be triggered throughout the program lifecycle as events necessitate. These messages are designed to provide up-to-date status information to the program participants through all phases of the process, including instructions on how to proceed to the next step of the process. We have developed a consistent framework and format to the messaging component to make it easier to add new messages as needed. Many messages will be system generated based on triggers that are configured based on the verified requirements of Iowa as determined during the Requirements Validation activities.

Medicaid Incentive360's Event Broker plays an important role. The Event Broker can be configured and allows messages to be distributed based on conditions that are setup using this table-driven mechanism. In addition, email messaging will allow program staff to communicate with groups of participants through the Event Broker (such as a broadcast message about system upgrades or downtime, etc.) when needed. Exhibit 4-24 presents the current set of standard email messages configured in Medicaid Incentive360 at the time of submission of this response. For ease of communication with the Business Services team, we prefix all messages with a two character code since many messages have similar names but have different usages.

Exhibit 4-30: Medicaid Incentive360 Standard Email Messages

Message Name/Description	Medicaid Incentive360 Requirement
C1-NOT-FOUND	No crosswalk to match b6

Message Name/Description	Medicaid Incentive360 Requirement
C2-WELCOME	Provider is able to enroll
C3-ACCT-UPD	User has updated account information
C4-CONFIRM-ENROLL	Provider has confirmed enrollment
C5-APPEAL-INITIATED	The provider has initiated an appeal
C6-APPEAL-RESOLVED	The appeal has been resolved.
C7-INELIGIBLE-ENROLL	The provider is ineligible - enrollment
C8-INELIGIBLE-AUDIT	The provider is ineligible - desk audit.
C9-APPEAL-ESCALATED	The provider has escalated the appeal.
C10-NLR-UPDATE	A B6 update transaction has been received.
C11-NLR-CANCEL	A B6 cancel transaction has been received.
C12-MMIS-PDC	MMIS Payment Denial Check
C13-PDC2-New-Payee-Reqd	The provider has failed PDC2
C14-StatePDC-New-Payee-Reqd	The provider has failed PDC during state payment
C15-Return-In-Progress	The provider's status has been set to In-Progress by BSC
C16-RESPONSE-D16	The provider has failed D16
C17-PAYMENT-DISBURSED	Notify user of payment disbursement
C18-D16ERROR-RESPONSE	Notification of D16 Error
C19-Invalid-Provider-Type.	The provider type is invalid for the EHR Program
State-STARTUP	State Start-up Mass Mailing to invite providers
U1-Password-Notification	Notify user of single use password
U2-Update-Password	Notify user of password update

Medicaid Incentive360 provides the ability to submit email notifications to provider with the information and requirements for eligibility upon receiving registration from the NLR. If the internal crosswalk check is confirmed, Medicaid Incentive360 will generate an email notification to the provider acknowledging receipt of the NLR registration and providing instructions on how to continue with State Registration. Should the crosswalk check not be confirmed, Medicaid Incentive360 will generate an email message to contact the State MMIS administrator to check provider status.

b. Making all EHR program determination using a rules-based determination system.

The only purpose of the Medicaid Incentive360 solution is to provide the tools to administer the Medicaid EHR Incentive Program on behalf of our client states in accordance with the rules and regulations. To accomplish this, CGI has carefully analyzed the program rules and regulations and designed our system to be able enforce the rules as they exist, recognizing the high likelihood that they will continue to evolve as

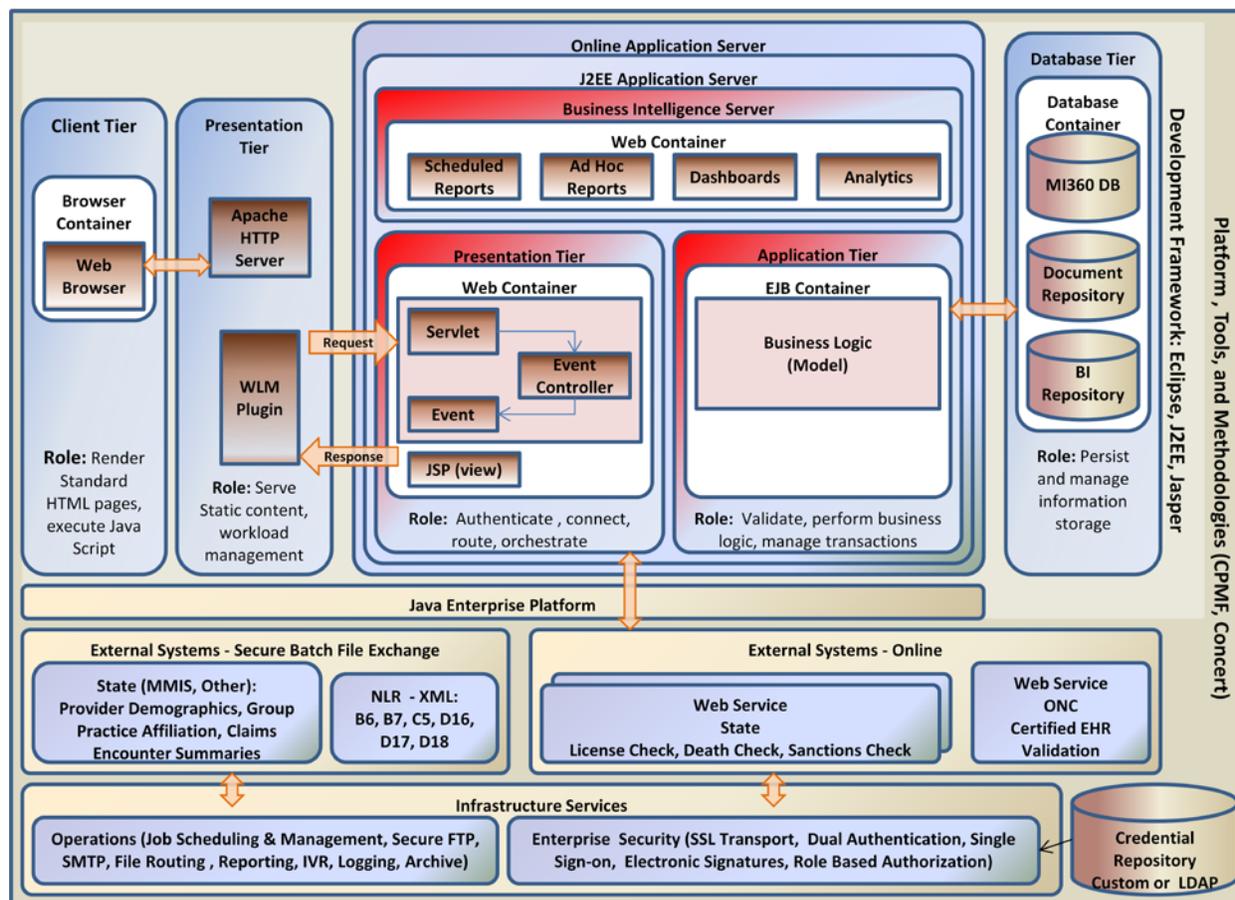
the program matures. Understanding the business requirements and the associated processes before developing a technology based solution is tantamount to a successful software solution.

To support and encapsulated rules-based engine, CGI employs the industry standard multi-tiered application architecture for the Medicaid Incentive360 system. This topology utilizes mature industry standard technologies and components in a cohesive framework that provides each user with a singular view of the application while each tier performs its role independently. This independence enables components to be scaled vertically or horizontally to meet increased capacity and redundancy where it is needed without service disruption. In addition the tiered topology facilitates the compartmentalization of services that host sensitive information to protect it from direct exposure to attack on the internet.

The tiered object oriented architecture enables flexibility in expanding the functional scope of the application with minimal impact. The application is built on a standard event model and hierarchy of standard interfaces and abstract classes. This approach minimizes the dependencies between application components, enabling maintenance and upgrades to core services with minimal changes required in the service consumers across the application.

Exhibit 4-31 presents the architectural tiers of the Medicaid Incentive360 solution and a description of the role of each respective tier, including the business rules engine. We present a brief description of each of the primary tiers of this n-tier architecture after the diagram.

Exhibit 4-31: Medicaid Incentive360 Application Architecture



Client Tier

Medicaid Incentive360 implements a thin HTML client for maximum flexibility and no client software distribution (e.g., zero client footprint). This architecture minimizes the impact to the network relative to other client-centric models. Our thin client is responsible only for rendering HTML and JavaScript, both Web browser standards. The client is responsible only for transmitting user requests and displaying the results of a user request (i.e., service request model).

The web browser will support the providers, as well as administrative users such as state administrators and business service center users.

Technologies used in this tier include any compliant web browser such as Internet Explorer, Firefox, or Safari.

Presentation Tier

The Medicaid Incentive360 presentation tier is responsible for presentation services including page navigation, session management, and transaction request management. The Medicaid Incentive360 presentation tier is implemented as a thin layer using a Web and application server. On receipt of a request, the Web server acts as a broker and passes the HTTPS request to the appropriate transaction

handler on the application server. The application server is responsible for processing requests. The results of the completed request are then passed back through application server for presentation processing and then back through the Web server to the client Web browser for rendering, serving HTML pages through HTTPS.

CGI's Medicaid Incentive360 solution, as necessary, employs multiple web servers to support horizontal scalability for load-balancing and fail-over through a load-balancing switch.

Medicaid Incentive360 does not process business logic at the Presentation tier. Instead, it supports presentation processing in the J2EE application server. Medicaid Incentive360 logically processes user requests by passing them to the Medicaid Incentive360 servlet that invokes an "Event Controller" for that business process. This controller is responsible for calling the business logic appropriate for that transaction. As such, it acts as the "traffic cop" of the application—mediating between the Web components and the EJB components.

Technologies used in this tier include Apache Web Server, OpenSSL, Mod-jk, and Apache Tomcat. The servers run on virtualized environments in a clustered configuration. This provides redundancy, fault-tolerance, and eliminates any single point of failure.

Application / Logic Tier

The application tier maintains the business logic and core application processes of the Medicaid Incentive360 solution. Medicaid Incentive360 adheres to a true n-tiered architecture and is built using a service-oriented architecture. The application tier is responsible for processing requests, calling a service layer which in turn invokes the appropriate business rules. Business rules call a persistent layer which performs all data access.

Medicaid Incentive360 uses the J2EE specification to support an open, non-proprietary architecture. Some J2EE standards used by the Medicaid Incentive360 solution include Enterprise Java Beans (EJB), JavaMail (SMTP, POP3 support), eXtensible Markup Language (XML) for transaction data formatting, and Java Persistence Architecture (JPA).

The application tier executes within the Enterprise Java Beans (EJB) container and provides a high performance execution environment for managing a number of logical processing layers that encapsulate Medicaid Incentive360 functionality.

Technologies used in this tier include JBoss. As with the Tomcat server, the JBoss servers will also run in a virtualized environment in a clustered configuration.

Persistence / Database Tier

The database server tier performs the data storage functions and is implemented using industry-leading relational database management systems (RDBMS). The Medicaid Incentive360 application components access the RDBMS using JPA. The RDBMS supports a wide range of reporting options. Within this tier, we strictly process standard SQL requests. No business logic (e.g., in the form of embedded stored procedures) is executed within this tier, in compliance with current Web application best practices for portability and platform independence.

The EJB container provides transaction processing, resource pooling, security, and persistence for improved performance and scalability.

Technologies used in this tier include Microsoft SQL/Server. SQL/Server will run on stand-alone database servers arranged in a master/slave failover cluster configuration. Each participating State will have its own separate database.

c. Tracking payment authorization.

Medicaid Incentive360 is the system of record for all of the Medicaid EHR Incentive Payment data, from the initial payment calculations and attestations, through audit results, payment requests made through the MMIS or state Financial System through recording of the actual warrants disbursed. Each step of the payment process is tracked in the system, including the identification of the users that provide approvals along the way.

The participant's record is in a payment pending status until eligibility is confirmed and all desk audits are complete. As a provider's enrollment clears the audit process, the payments are staged for release. The State of Iowa and CGI will confirm the frequency of payments – daily, weekly, monthly, quarterly. Because there may be a gap between the time a provider is eligible for payment and the actual payment date, the record will be in a “payment pending” status. Immediately prior to payment, Medicaid Incentive360 will send a file (D-16) to the NLR to confirm provider standing and safeguard against duplicate payments.

In addition, Medicaid Incentive360 will perform a final state level check to guard against any payment denial codes (sanction, death, other exclusion) that might prevent payment. Once the record is cleared, the “payment pending” status is removed and a payment voucher file will be created. CGI works with every client to understand the payment paths and will collaborate with Iowa to route the voucher file through the appropriate state systems. Following disbursement, the state system will response to the payment voucher request with confirmation to the Medicaid Incentive360 system. Medicaid Incentive360 will then send the D-18 payment interface file which includes amount calculated, amount disbursed, and adjustment reason to the NLR as required. Prior to payment, Medicaid Incentive360 will confirm via state interfaces and MMIS system data to confirm that providers are still eligible to be staged for payment. With this information, Medicaid Incentive360 sends a Payment file (D-16) to the NLR to confirm provider standing and safeguard against duplicate payments. Final checks against Iowa provider information for exclusions, death, or outstanding A/R will confirm that nothing should stop payment.

Medicaid Incentive360 will be the authoritative system of record for all Medicaid EHR Incentive Payments to the eligible participants. The system is configured to support any of the following payment approaches:

- ▶ Payments made through MMIS
- ▶ Payments made by state financial system
- ▶ EFT Payments processed by Medicaid Incentive360

All transactional history will be maintained in Medicaid Incentive360.

d. Providing any required audit support.

CGI proudly includes audit support functions as a critical part of the Medicaid Incentive360 solution to protect against fraudulent participation and payments. Audits may occur at any time and any point of the process, although consensus from the States show most prefer pre-payment audits to confirm that the money is flowing to the appropriate, eligible entities. For our audit process, it is important to understand the complete methodology. CGI has implemented configurable tools to provide automated and manual review assistance as well as reporting. CGI's audit methodology is rooted in our best practices and the need for quality project outcome – in this case, incentive payments disbursed to the intended, qualified participants.

CGI has a series of incremental checks in the audit process to confirm that qualified, eligible providers are the only ones receiving program payments. During the requirements validation, CGI will work with IME to confirm the desired criteria that would trigger an audit, such as attestation completeness, use of certified EHR, appropriate Medicaid patient volumes, federal and/or state sanctions, non-hospital-based, certified EHR cost information, future meaningful use and clinical quality measure data. As one example, CGI has a table-drive reasonableness test where the system evaluates whether the entered patient volumes and/or panel counts exceed a state specified deviation threshold when compared to the MMIS claim and panel volumes. If a deviation is identified, the enrollment is flagged for a desk audit, suspending the subsequent payment processing until the audit has been resolved in accordance with the policies and procedures defined by the State during our initial design activities. CGI will work with the State to configure appropriate reasonableness checks for Iowa.

- ▶ Establish systematic targets, and sampling sizes for audits by Iowa's Medicaid Enterprise.
- ▶ Configure the workflow to create the audit cases
- ▶ Setup parameters for audits to include systematically selected desk audits
- ▶ Establish criteria for random audit case selection, if desired
- ▶ Recommend language for outbound communication that can be sent to EPs and EHs indicating the nature of the audit and required actions.
- ▶ Provide training on audit processes to be used for logging and working audit cases correctly and consistently
- ▶ Implement standard reports providing audit tracking and summary statistics (number under review, case status, etc.)

Through CGI's Medicaid Incentive360 solution, authorized CGI Business Services and State staff will have privileges to the audit process and work queue. Cases are selected for review by state staff where they can review why the case is being audited and examine whether more information is needed from the provider. While the case is in audit, the record will indicate "payment pending" to prevent it from being paid before the audit is complete. Authorized State staff will have access. Exhibit 4-32 shows a component of an audit view where authorized state staff can add comments and complete the audit process.

Exhibit 4-32: Audit View

Medicaid Incentive360 YourState.com :: CMS.GOV :: Help

[Logout](#)

[Home](#) | [Provider Status](#) | [Appeals](#) | [Account Management](#)

Roger Austin – Provider: Bill Lawson Sr. (NPI-2987456094)

View Audit

Audit details are listed below. Click the "New Comment" button to add a comment or "Return to Summary" to return to the Provider Summary page.

Enrollment Information

Enrollment ID:	3482233	Enrollment Status:	Payable
Name:	Bill Lawson	Email Address:	Bill.Lawsonn@healthcare.com
Legal Business Name:		Program Year:	2012
Address:	287 Rangle Drive, Suite 2 San Antonio, TX 39654-9087	Participation Year:	2
Phone #:	(512) 619-6498	Tax ID:	xxx-xx-9292 (SSN)
Alt Phone #:	(512) 952-6499	NPI:	2987456094
		MMIS Provider ID:	845298654
		CCN:	

Audit Information

Audit ID:	786	Status:	Completed
Category:	Patient Volumes	Initiated Date:	01/14/2011
		Completed Date:	01/20/2011

Audit Description: This audit was initiated because: Provider Medicaid volumes are over the variability threshold.

Audit Disposition: Passed Audit **Enrollment Status Change:** No

Disposition Comment: Claims information provided was incomplete as there are still outstanding claims for the reporting period chosen by this provider.

Audit Comments

Name	Date/Time	Comment (2000 Character Max)
MI360 System	01/14/2010 8:25:16AM	Audit Initiated.
Jennifer Eschle	01/14/2010 5:45:34PM	Accepted audit – will begin review of enrollment data today.
Jennifer Eschle	01/17/2010 08:41:39AM	Documentation uploaded supports provider volumes. Checking validity of claims data from state.
MI360 System	01/20/2010 11:16:36AM	Audit Completed.

[View Provider Summary](#) | [View Provider Details](#) | [View Search Results](#) | [New Provider Search](#)

e. Providing any support, including testimony, on EHR program decisions before any administrative or judicial tribunal.

CGI will provide clarifications on all system business rules and how systematic decisions are rendered in accordance with these system enforced business rules as required to substantiate the results as required by the State.

f. Providing access to a system dashboard, with up-to-date information related to all registrations in the system.

Medicaid Incentive360 provides access to a powerful system dashboard that provides up-to-date information on multiple aspects of the program, including information related to all registrations in the system. This information displays the program key performance indicators. For example, there will be

indicators on provider enrollment, provider type, final eligibility determinations, payments, appeals and disputes, audits, etc.

This dashboard is available through the Business Services Portal based on role based security. Exhibit 4-33 presents a screen print of the Business Services Home page, with the Dashboard option highlighted.

Exhibit 4-33: Business Services

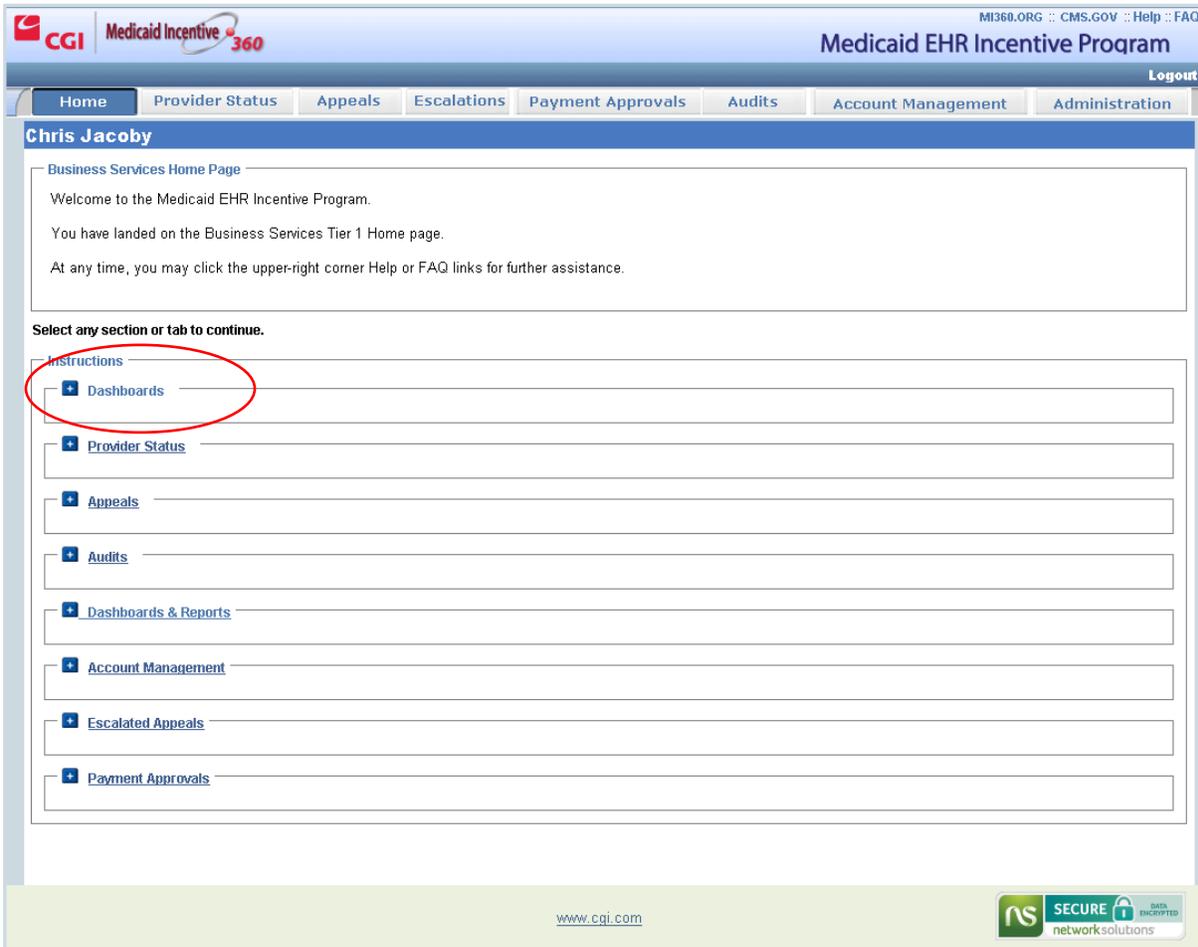


Exhibit 4-34 presents a sample of one of the currently existing four dashboards presenting the Appeals and Audit status for a fictional implementation. This dashboard is rendered in real-time when selected in the previously presented screen.

Exhibit 4-34: Audits and Appeals Dashboard Sample



As presented earlier, we anticipate developing and deploying additional dashboards throughout the life of the Medicaid Incentive360 program. These will be made available to all clients.

g. Providing workflow management (or interface to the Agency's OnBase workflow system).

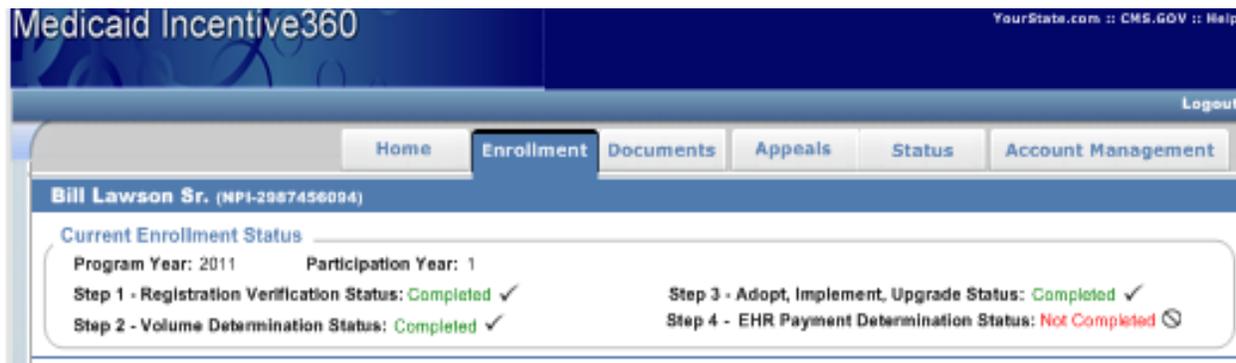
Workflow management is incorporated in the Medicaid Incentive360 application for the following processes, as described below:

- ▶ Provider Enrollment and Attestation
- ▶ Payment Processing
- ▶ Appeals Processing
- ▶ Audit Processing

Provider Enrollment and Attestation

The provider enrollment and attestation process, for both EPs and EHs, utilizes a workflow driven widget that guides the program participant sequentially through the following four steps for enrollment and attestation as presented in the enrollment status section of the Medicaid Incentive360 provider portal pages represented in Exhibit 4-35.

Exhibit 4-35: Enrollment Workflow



Payment Processing

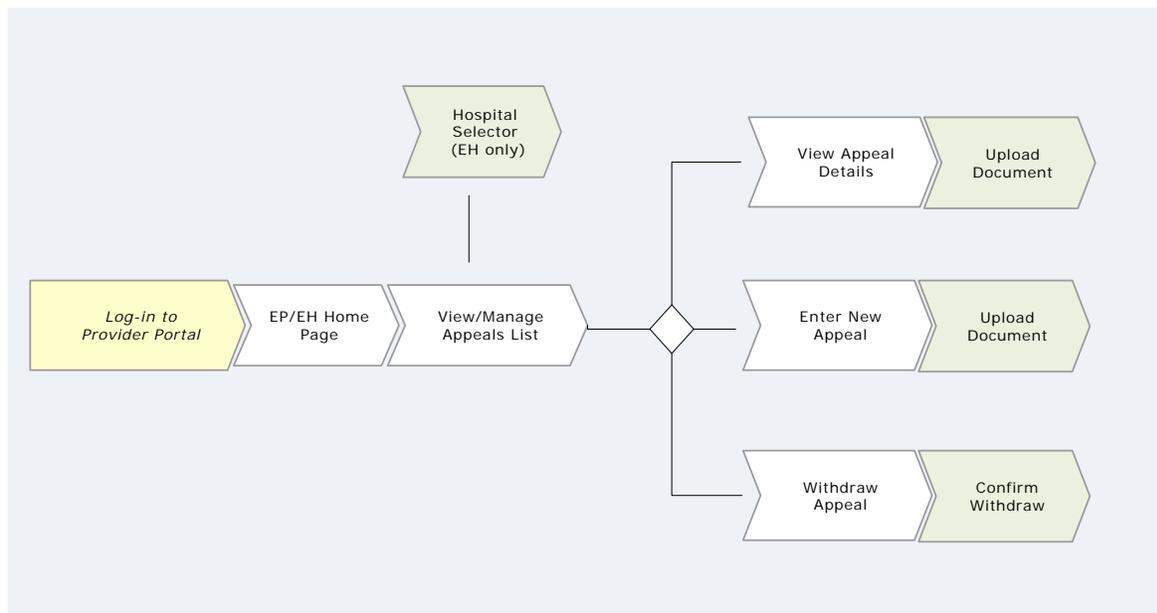
Medicaid Incentive360 Payment Processing workflow consists of the sequential set of actions and events after a program participant has successfully completed the Enrollment and submitted their attestation. At this point in the process, Medicaid Incentive360 performs the following sequential validations prior to finalizing the payment process:

- ▶ Apply Audit Trigger Criteria (configurable system function)
- ▶ Payment Processing (state administrative function)
- ▶ D-16 Provider Status and Duplicate Payment Check (automated NLR interface)
- ▶ MMIS/State Financial System Payment Request (system function)
- ▶ D-18 NLR Payment Update (system function)
- ▶ Post-payment Audit (manual state administration function)

Appeals Processing

Medicaid Incentive360 supports the Appeals workflow as represented in the following workflow, Exhibit 4-36, and described in our previous response to Deliverable 1.1 requirement.

Exhibit 4-36: Appeals Workflow Process



Audit Processing

Medicaid Incentive360’s Audit Processing function provides workflow control of the assignment, processing and resolution for the system generated desk audits. The online functionality is supplemented by the standard summary and detailed Audit Status Reports providing visibility of audit workload distribution and aging status.

h. Creating an on-line user manual.

Medicaid Incentive360 has been designed to be a very intuitive utilizing industry standard user interface design standards and widgets with the objective of eliminating the need for training as well as real-time support. To date, this solution has achieved this goal with less than one half of one percent of the more than 1,350 providers who have completed the process and received payment without requiring technical assistance.

Even with this level of proven intuitive usability, CGI will develop an on-line user’s manual specifically for the State of Iowa Medicaid Incentive Payment Administration Tool participants to guide them in the use of the online system. We will work with IME to confirm that content and level of detail during the Requirements Validation activities of the project.

i. Creating and distributing training materials.

CGI’s Medicaid Incentive360 baseline solution includes standard training materials that can be tailored by updating the training presentation with IA Medicaid Incentive360 screens and specific business processes. After updating the training materials, CGI will conduct one webinar for Eligible Professionals

and one webinar for Eligible Hospitals. IME can record these webinars and make them available to providers on IA Medicaid EHR Incentive Program website for future educational and training purposes.

In addition to provider training materials, the following are the anticipated IA EHR Medicaid Incentive Payment Administration Tool Staff Training modules that CGI proposes to utilize for IME staff:

- ▶ Module 1: CMS Electronic Health Record Program Overview
- ▶ Module 2: EHR Provider Incentive Program plus Provider Portal Overview Plus EHR Provider Incentive Program State Portal Overview
- ▶ Module 3: Enrollment Management
- ▶ Module 4: Part I Payment Process Overview and Rejecting Payments
- ▶ Module 4: Part II Approving Payments & Medicaid Incentive Payment Adjustments
- ▶ Module 5: Appeals Process, Initiation, Adjudication, Escalation and Resolution
- ▶ Module 6: Audit Process, Initiation and Resolution
- ▶ Module 7: Part I Dashboards and Reports (standard)
- ▶ Module 7: Part II Dashboards and Reports (ad hoc)
- ▶ Module 8: System Maintenance (System Help/FAQs, Home Page Text, Provider Notifications)
- ▶ Module 9: CMS and State Interfaces Overview

To maximize the effectiveness of the training, we recommend grouping the training modules into a series of sessions that cover the following:

- ▶ **Modules 1-6:** Conduct Half-Day Training Session(s) for IA EHR Provider Incentive Program Administrative Functions. All administrative functions will be covered during the half day session. Depending on IME staff availability and workloads, we can support up to four (4) training sessions.
- ▶ **Modules 7 Part I, 8 and 9:** Conduct one (1) Half-Day Training Session for EHR Provider Incentive Program System Administration.
- ▶ **Module 7 Part II:** Conduct Half-Day Training Session(s) for EHR Provider Incentive Program Reporting Users. All ad hoc features will be covered during the half day session. Depending on IME staff availability and workloads, we can support up to two (2) training sessions.

Therefore, the training time per person could range from 4-10 hours based on their EHR Provider Incentive Program role.

CGI will conduct instructor-led State IA EHR Incentive Payment system training using Iowa's User Acceptance Test (UAT) environment and PowerPoint Presentations.

j. Providing extensive system messaging to internal staff.

Medicaid Incentive360's flexible Communications Engine can be configured to include internal staff on all system generated communications. During the Requirements Validation phase of the project, CGI's

Medicaid Incentive360 implementation team will work with the IME team to confirm the specific communications that they desire to be directed to internal staff.

4.1.3 REPORTS

3. Provide reports as required, including the following online administrative reports:

CGI’s Medicaid Incentive360 solution includes a base set of dashboards and standard reports that will provide Iowa with multiple levels of insight into the progress of the program across all of the project domains. As CMS guidance and regulations evolve, we expect that our base set of reports will also evolve to meet the needs of our participant states. Exhibit 4-37 provides a list of base reports that map to Iowa’s RFP requirements and are currently included in Medicaid Incentive360. In addition, authorized users will be able to log on and access our online ad-hoc reporting tool.

Exhibit 4-37: Medicaid Incentive360 Standard Reports

Report	Description
Summary Enrollment Activity Report	This report provides summary information on those EPs and EHS who are participating in the Medicaid EHR Incentive Payment Program. It contains information on the number of providers who have registered at the Federal NLR level and those going through state registration/enrollment process. See below for an example of this report.
Summary Attestation Activity Report	This report provides summary information (including date and time stamp of attestation) on providers (EP and EH) as they attest to submitted data. Attestation summary information will be collected for enrollment Step 1 - Registration Verification, Step 2 – Volume Determination, Step 3- Adopt, Implement, Upgrade, and Step 4 – Payment Acknowledgement.
Payment Summary Report	This report provides summary information on payments made to EPs, EHS, and/or Assignees. This payment report will include Name, Organization, Provider type, Amount, payment date.
Audit Activity Report	The Audit Report provides summary information across all types of audits. Data will be summarized to show number of audits by type. In addition, a provider detail report will provide detailed information about a specific individual audit conducted. Information will include: Case ID Number, Name, Organization, Audit Purpose, Audit Status, Audit Open Date, Audit Findings, Audit Close Date.
Clinical Meaningful Use/Clinical Quality Measures	Across designated provider types, the Clinical Meaningful Use Measures Report will show information specifically related to Meaningful Use and quality measures – including, necessary State or Federal reporting specifications as required.
Appeals Activity Detail and Summary Report	The Appeals Report provides summary information on all types of disputes and information will be summarized to show number of disputes, by year and by reporting period (generally weekly).

Report	Description
Reassignment of Provider Payments Provider Payment Reassignment	Summary information showing the number of payments that have been re-assigned and to whom along with date/time stamp.
System Utilization Statistics Provider Activity Report	This report provides summary information on Eligible Professional and Eligible Hospital Users who are accessing Medicaid Incentive360. It will contain information on the number of site visits to the program by EP and EH for each day of the week.
Summary and Detail Report of Workflow Activities	This Report provides useful information about providers process navigating through the system
Payment Approved Aging Report	The Payment Approved Aging Report provides the Business Services user with the aging data on the incentive payment requests that have been submitted, entered into the payment queue, and are now approved.
Daily Batch Summary Report	This report presents the summary of the NLR transactions received in the daily B6 file and the corresponding communications generated as a result of the daily file as well as the previous days' system enrollment and attestation activity.
Program Statistical Summary Report	This report provides current program statistics for provider registration, enrollment, attestation and payment status. It includes the amount of incentive funds paid to date, as well as the amount of current year pending payments based on providers who have not completed the attestation or are in audit process. In addition, it projects the payments for subsequent years based on those currently paid as well as those pending.

a. Provider activity report.

Medicaid Incentive360 includes a standard Program Statistical Summary Report which includes current program statistics regarding the status of the providers at all phases of the process. This report provides a week by week status of the provider registrations through CMS, Medicaid Incentive360 access, enrollment status, payment pending status as well as payments that have been disbursed. This report provides the State administrators the information to support the CMS37 and CMS64 reporting requirements.

b. Registration summary.

Medicaid Incentive360 includes a standard Summary Enrollment Activity Report provides summary information on the EPs and EHs who are participating in the Medicaid EHR Incentive Payment Program. It contains information on the number of providers who have registered at the Federal NLR level and those going through state registration/enrollment process.

c. Attestation summary.

Medicaid Incentive360 includes a standard Summary Attestation Activity Report that provides summary information, including date and time stamp of attestation, for EP and EH providers as they attest to submitted data in the system. Attestation summary information will be collected for enrollment Step 1 - Registration Verification, Step 2 – Volume Determination, Step 3- Adopt, Implement, Upgrade, and Step 4 – Payment Acknowledgement.

d. Payment summary report(s).

Medicaid Incentive360 includes a standard Payment Summary Report that provides summary information on payments made to EPs, EHs, and/or Assignees. This payment report includes Name, Organization, Provider type, Amount, and payment date.

e. Dispute and appeals activity report.

The Appeals Activity Detail and Summary Report provides both summary and detailed level information on all types of disputes and information will be summarized to show number of disputes, by year and by reporting period (generally weekly).

Real-time Appeals activity and status is also available through the Business Services Portal as well as the ad-hoc reporting feature of Medicaid Incentive360.

f. Aggregated meaningful use report identifying measures selected by providers.

Medicaid Incentive360 includes reports on Clinical Meaningful Use Measures across designated provider types. The Clinical Meaningful Use Measures Report will show information specifically related to Meaningful Use and quality measures – including, necessary State or Federal reporting specifications as required. This report is currently being designed and developed for our next release that will be live no later than January 1, 2012.

4.1.4 INTEGRATION WITH MMIS

4. Receive EHR incentive payment information from MMIS.

Medicaid Incentive360 is designed to leverage provider demographic, enrollment, claim summary, status data and incentive payment data from the state MMIS and Data Warehouses to facilitate the evaluation of the provider's qualification to participate in the program in accordance with the requirements as presented in the Final Rule. Specifically, Medicaid Incentive360 is designed to consume the following data from the local state MMIS environment:

- ▶ **Provider Demographics Data** – Used to validate the information provided on the NLR B-6 transactions and confirm that the provider is known and registered with the Iowa MMIS. Throughout the process, a provider's standing must be checked to confirm they are not sanctioned and are a properly licensed/qualified provider. We assume this information is

contained with the provider profile of the MMIS, but in the event it is not, CGI will work with you to determine the most efficient approach to obtain the information.

- ▶ **Provider Groups** – Used to identify any group affiliations that a provider has
- ▶ **Claims Summary** – Summary of Medicaid claims by type and service location for the provider
- ▶ **State Sanctions Exclusions** – May be included in the Provider Demographic Data
- ▶ **MMIS Payment Data** – Information associated with the incentive payment including actual paid amount, date and warrant number, where appropriate
- ▶ **MMIS validation/crosswalk for providers** – Once a provider has selected Medicaid and that record is received from the NLR, our solution will map this provider’s record within the current MMIS system to extract IA specific demographic information.
- ▶ **Portal Integration** – Medicaid Incentive360 has the capability to integrate with existing IME systems to provide the benefits of Single Sign On, if desired.

4.1.5 INTERFACES WITH CMS NATIONAL LEVEL REPOSITORY

5. Interfaces to the CMS National Level Repository, by:

- a. Accepting a daily feed and applying that information to the State repository.*
- b. Sending updated daily feeds to CMS.*

The Medicaid Incentive360 solution includes automated processes to receive and process the daily National Level Repository (NLR) interface file from CMS. The system stores all information provided in interface record in the system as well as use them to appropriately build or update data records in the Iowa system.

Similarly, Medicaid Incentive360 generates daily outbound NLR interface files to CMS based on the results of the previous days’ program enrollment and payment processing activities. We provide an overview of the general Medicaid Incentive360 integration approach, including the NLR interfaces, in the remainder of our response to these requirements representing the integration approach for the program workflow.

The Medicaid EHR Incentive Program is successfully operated through the careful integration of data from three primary sources:

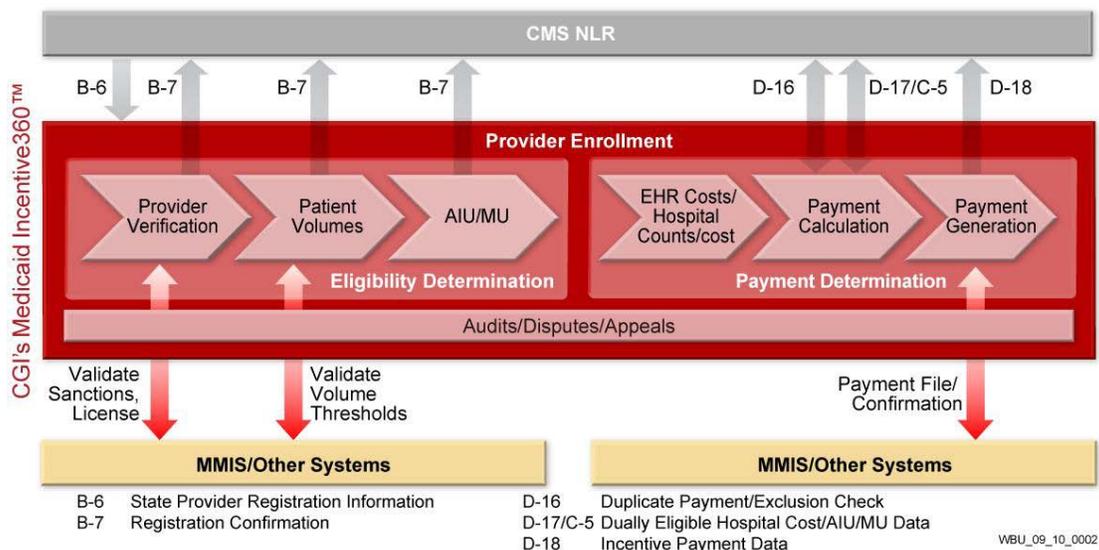
- ▶ CMS NLR Registration, Eligibility and Payment Validation
- ▶ State Medicaid EHR Incentive Program – Enrollment, AIU, Meaningful Use Attestation, and Incentive Payment Amounts
- ▶ State Systems – MMIS data, Financial Systems

The integration between these systems is accomplished through a set of precise interface transactions established by CMS. CGI has developed a deep understanding of each of these interfaces and is confident that we can complete the required NLR interface tests with CMS with unparalleled expediency and efficiency.

Exhibit 4-38 presents the interface touch points between Medicaid Incentive360, the NLR and State systems. Within the Medicaid Incentive360 system, providers will follow a user-friendly, straightforward

process for eligibility determination and payment determination, insulated from the behind the scenes complexities of the different entities involved.

Exhibit 4-38: Medicaid Incentive Interface Overview



CMS Interfaces (NLR)

CGI understands the processes and the complexities involved with validating a provider’s adherence to the meaningful use criteria. There are a significant amount of data exchanges and transactions that will occur between Medicaid Incentive360 and the NLR that includes validation against exclusion and master death lists maintained at the Federal and State level. Medicaid Incentive360 processes this data as part of the B-6 transmission and stores the result for later reference and use within the application workflow.

Medicaid Incentive360 has successfully passed the testing for NLR Group 1 on behalf of the State of Texas and has more recently been used to help the State of Ohio achieve NLR interface certification in near record time. The application supports interfaces with NLR including B-6, B-7, D-16, D-18, D-17 and C-5. In addition, CGI provides base interface models for the interfaces and into Iowa’s environment, such as the MMIS validation/crosswalk for providers, provider standing, and payment file generation. Exhibit 4-39 presents detailed information on each interface and error batch processing routine.

Exhibit 4-39: NLR Interfaces and Processing Description

NLR Interface Code	NLR Interface Name	Processing Description
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NLR Interface Code	NLR Interface Name	Processing Description
B-6	NLR - State, Provider Registration Information	<p>The NLR B-6 Interface will be sent to the Medicaid Incentive360 system once daily. The B-6 interface will include all Add, Updated, and inactivated registrations initiated by Eligible Professionals (EP) and Eligible Hospitals (EH) through the NLR system. The Medicaid Incentive360 system will ingest this file and begin processing as directed by the type of record received from NLR.</p> <p>This contains key demographic data used to validate the provider against state level MMIS data such as NPI, TIN and provider type.</p>
B-7	State-NLR, Registration Confirmation	<p>The purpose of the B-7 interface is to provide the NLR with current Medicaid Incentive Program Eligibility Status. The B-7 interface is an outbound interface which sends EP and EH eligibility information to the NLR on a daily basis. The NLR does not respond to this interface. The B-7 is an outbound interface only.</p>
D-16	State-NLR, Duplicate Payment, Exclusion Check	<p>Request from States:</p> <p>The D-16 State – NLR, Duplicate Payment / Exclusion Check interface is a process defined by NLR to be utilized by States prior to approving Incentive Payments to Eligible Professionals (EP) and Eligible Hospitals (EH). The D-16 is a two way interface. Prior to payment approval, States will send NLR a D-16 Request file. The file will contain EP / EH Provider Identification, potential payment amount, payment type, as well as additional payment information.</p> <p>Response from NLR:</p> <p>CMS accepts D-16 files from States daily. The D-16 is then processed by NLR to determine if the EP/ EH has received or is scheduled to receive a payment in another State. The NLR also checks to determine if any new Federal or Out of State Sanctions or death have been reported. The NLR then returns the D-16 file back to the State in the D-16 response format. The D-16 Response file is received by the State and processed according to the results of the Duplicate Payment and Sanctions check. The result may include payment of the incentive amount or an update of the Eligibility Status to Not Eligible resulting in a Non Payment.</p>

NLR Interface Code	NLR Interface Name	Processing Description
D-18	State-NLR, Incentive Payment Data	<p>The purpose of D-18 State – NLR, Incentive Payment Data is for States to Update NLR with updated successful and unsuccessful incentive payment information for Eligible Professionals and Eligible Hospitals.</p> <p>Following the successful or unsuccessful disbursement of an incentive payment to an EP / EH, the D-18 interface will be initiated by the State. The D-18 interface will include information regarding the amount of money actually disbursed and the method used to disburse the funds.</p> <p>The sending of the D-18 interface file signifies the completion of an EP / EH program year processing resulting in the payment of the EP/EH.</p>
C-5	Dually Eligible Hospital Data	<p>The purpose of the C-5 NLR-State is to enable the NLR to send States attestation information submitted by Dually Eligible Hospitals via the CMS Attestation Module.</p>
D-17	Hospital Cost Report Data	<p>The purpose of the D-17 NLR-State is to enable the NLR to send States the cost report data elements utilized by CMS to determine Medicare hospital payments for Dually Eligible hospitals deemed eligible for the Medicaid HITECH incentive payment. The state will receive the cost report after a Dually Eligible hospital successfully attests for Medicare and the cost information is retrieved from the Shared Systems.</p> <p>The Medicare cost report is for information only to the states as an aid to use in computing the Medicaid payments.</p>

During the course of transaction processing between the state Medicaid Incentive360 system and CMS’s NLR, it is possible that errors occur which result in the suspension of processing for an entire file, or for individual records contained in transaction file. Communication of these anomalies identified by CMS to the originating entity is supported through the NLR Batch Error Interface file.

The CMS NLR Batch Error interface file provides the communication mechanism between CMS and states for these kinds of errors. The Medicaid Incentive360 team evaluates each of these anomalies upon receipt to identify the cause and develop the appropriate remediation plan.

4.1.6 INTEGRATION WITH AGENCY’S DATA WAREHOUSE

6. Provide requested data extracts for the Agency’s Data Warehouse.

CGI has included in this proposal effort to provide requested data extract for the Agency’s Data Warehouse. The Medicaid Incentive360 system maintains an expansive set of state Medicaid EHR Incentive Program related information in the state-specific database. As the program progresses from the

first payment year through to up to six years for the EPs, the system will be custodian to an increasing amount of Meaningful Use and Clinical Quality Measures data that will be extremely valuable to assist the State in conducting analysis and identifying and tracking the benefits of the broad utilization of EHR technology.

The Medicaid Incentive360 database is highly normalized to allow for maintaining the data details and integrity throughout the life of the program. Medicaid Incentive360 provides a limited set of business intelligence capability, but it is anticipated that the State Medicaid services may want to utilize this information in conjunction with the other data that is managed and aggregated during the normal Medicaid administration processes.

CGI will work with the Iowa IME Data Warehouse stakeholders to identify the specific data of interest and develop the mutually agreed upon approach to harvesting the Medicaid Incentive360 data and providing it to the Iowa Data Warehouse. Our philosophy is that we are curators of the data that is owned by the State and look forward to working with you to identify the best approaches for leveraging this information to achieve the broad goals of the program.

4.1.7 APPLICATION SUPPORT

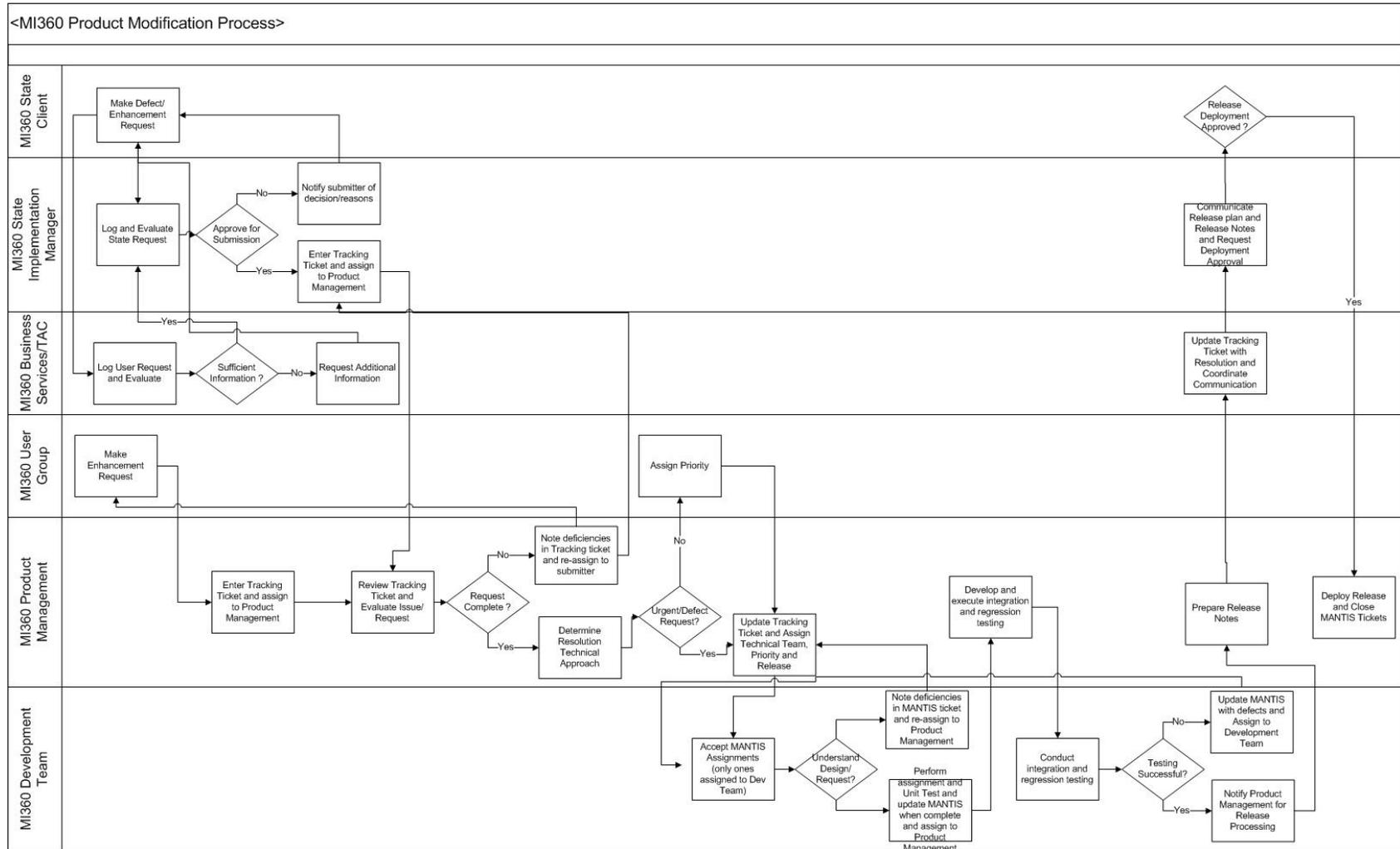
7. Provide Application support for the life of the contract.

CGI will support the Medicaid Incentive360 application through the longer of the life of the contract with the State of Iowa or the life of the ARRA HITECH Medicaid EHR Incentive Program.

An effective application support model is essential on any project but it is of utmost importance in a multi-state model. A key component of CGI's model is the sharing of the common solution and approach. With this in mind, CGI has spearheaded the development of an effective multi-state application support methodology which allows each state the flexibility to initiate their own defects and/or unique modifications while allowing for the other participant states the opportunity to share the common functionality. Exhibit 4-40 illustrates the Medicaid Incentive360 application support methodology.



Exhibit 4-40: Medicaid Incentive360 Application Support Methodology





The goal of CGI's Medicaid Incentive360 system is to be the most efficient and effective EHR Incentive Program solution for our state client stakeholders and CMS. We have coined a motto that summarizes our philosophy – "Collaboration through Cooperation." The goal of the Medicaid EHR Incentive Program is to motivate the adoption and utilization of EHR technology to improve the overall quality and efficiency of the provision of care to the ultimate stakeholders - the recipients of medical care.

There are many different stakeholders in the Medicaid EHR Incentive Program, each of them impacting the current and future direction of CGI's solution offering. These stakeholders consist of:

- ▶ **Medicaid Incentive360 User Group** – Consists of representatives from each of the Medicaid Incentive360 client states. Primary responsibility is to confirm that the Medicaid Incentive360 solution supports the state's administration of the program by maximizing validated, righteous participation. We encourage active, creative participation and guidance from the Medicaid Incentive360 User Group. Creativity drives innovation. We look forward to representation and participation from the State's team.
- ▶ **CMS** – As the overarching governing body for the Medicaid EHR Incentive Program, it is imperative that CGI maintain a finger on the pulse of CMS policies as they are clarified and evolve as the program progresses and matures. CGI is proud to cooperate with CMS in identifying solutions to unforeseen challenges in the technical and operational management of the program.
- ▶ **Regional Extension Centers (RECs)** – CGI recognizes the tremendous value that the RECs provide in working with the provider community and encourage the inclusion of them in the preparation and outreach processes. As an aggregator of provider feedback, they provide important feedback from the trenches that can be used to tune our processes and solutions.
- ▶ **Eligible Hospitals** – As a key component of the Medicaid System of Care, it is important for the state Medicaid administrators and CGI Medicaid Incentive360 Program team to solicit feedback from the Eligible Hospitals for maximum participation and system usability and understanding.
- ▶ **Eligible Professionals** – As the other key component of the Medicaid System of Care, it is important for the state Medicaid administrators and CGI Medicaid Incentive360 Program team to solicit feedback from the Eligible Professionals to verify maximum participation and system usability and understanding.

Exhibit 4-41 presents a graphical representation of the Medicaid Incentive360 Product Evolution stakeholders and influencers.

Exhibit 4-41: Medicaid Incentive360 Product Evolution Process



As you may notice, we do not consider CGI as a primary stakeholder in this model. We view ourselves as program experts that provide a solution to the facilitation of the Medicaid EHR Incentive program. Our facilitation role requires that we maintain an objective perspective on the different guidance and input from the five primary stakeholders described. We will use our program expertise to help transform the guidance from the stakeholders into solution enhancements and refinements.

The first Medicaid Incentive360 User Group meeting was conducted on August 1, 2011 in conjunction with the MMIS Conference in Austin, TX. We plan to continue to schedule the primary annual User Group meeting with the MMIS conference, with quarterly conference calls to follow up on progress and tune priorities accordingly.



4.1.8 PROJECT IMPLEMENTATION PLANNING MATERIALS

8. Provide project implementation planning materials for the Agency's approval no later than 15 days following execution of the contract, including:

- a. A project work plan.*
- b. A project training plan.*
- c. A project timeline.*
- d. All application screen shots.*
- e. All sample reports to be used.*

CGI will provide the project implementation planning materials for the Agency's approval no later than 15 days following the execution of the contract. CGI has provided samples of all documents at the end of this section.

We have developed a detailed, draft project work plan specifically for the implementation of the State of Iowa's EHR Medicaid Incentive Payment Administration Tool. During the Project Inception activities, CGI will work closely with the IME project leadership to refine this plan to align with the State's schedules and constraints to provide a baseline, tactical roadmap for the successful implementation of the system.

4.1.9 SOFTWARE UPDATES

9. Provide all available updates to the software as they are released, as well as provide any updates required to meet attestation needs for future stages of meaningful use as defined by the federal government.

CGI will provide all available updates to the software as they are released, as well as provide any updates required to meet attestation needs for future stage of meaningful use as defined by the federal government.

The Medicaid Incentive360 Product Management team maintains a product roadmap that includes the schedule for applying enhancements to the baseline functions along with planning for future functional features such as the subsequent stages 2 and 3 of Meaningful Use. The Medicaid Incentive360 team conducts, at a minimum, quarterly assessments of the baseline solution to:

- ▶ Determine modifications to baseline design;
- ▶ Assess impact of changes in Federal Rules of CMS interpretation of these rules on the baseline design;
- ▶ Assess change in Operational Procedures for Business Services;
- ▶ Assess the repository of data collected from providers and state EHR staff MI360 states,
- ▶ After evaluating the results of this assessment across the above four dimensions, the Medicaid Incentive360 team updates the Medicaid Incentive360 roadmap and the plan for completing enhancements and incorporating functional requirements into the Medicaid Incentive360 baseline solution.

CGI is committed to maintaining Medicaid Incentive360 compliant with the most current rules and regulations as defined by CMS and reflected in the Final Rule for the entire 10 year duration of the Medicaid EHR Incentive Program. We will implement the Stage 1 Meaningful Use attestation capability for Eligible Hospitals on January 1, 2012, which is the first day they will be able to attest. Stage 1



Meaningful Use Attestation for Eligible Professionals will be available for production use by April 1, 2012, the first possible day to attest.

The next major evolution of the Medicaid Incentive360 system is the introduction of the electronic submission of the Stage 1 Meaningful Use and Clinical Quality Measures. We are anxiously awaiting the finalization of the standards and requirements from CMS.

Stage 2 Meaningful Use has been delayed until January 1, 2014, with Stage 3's schedule yet to be confirmed. Exhibit 4-42 presents the high-level Medicaid Incentive360 Product Roadmap. This roadmap is updated quarterly and reviewed with the Medicaid Incentive360 User Group for review and confirmation of priorities.

Exhibit 4-42: Medicaid Incentive360 – Product Roadmap Highlights

2011				2012				2013				2014				2015			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Year 1																			
<ul style="list-style-type: none"> • MI360 User Group Initiated 8/2011 • End of Year Processing 9/2011 • Payment Adjustment 9/2011 • Group Processing Enhancements 9/2011 • Section 508 (ADA) Compliance 12/31 • Stage 1 Meaningful Use 12/31 																			
				Year 2															
				<ul style="list-style-type: none"> • TBD Enhancements 															
								Year 3											
								<ul style="list-style-type: none"> • TBD Enhancements • Meaningful Use – Stage 2 12/31 											
												Year 4							
												<ul style="list-style-type: none"> • TBD Enhancements 							
																Year 5			
																<ul style="list-style-type: none"> • Meaningful Use Stage 3 (Tentative) • TBD Enhancements 			

4.1.10 SECURITY AND OPERATIONAL STANDARDS

10. Confirm, at all times, adequate security and operational standards to protect all information. All such standards must at all times meet with Agency approval.

CGI recognizes the importance of strict adherence to the standard security policies and standards governing the management of the information maintained in support of the EHR Medicaid Incentive Payment Administration Tool. The CGI project methodology meets the State of Iowa's standards as well as the guidelines published by the CMS.

CGI's technical architect staff will collaborate with the IME technical security representatives to validate the unique security and operational standards applicable to the Medicaid Incentive360 solution and verify the compliance approaches.



4.1.11 MITA STANDARDS FOR SOA AND INTEROPERABILITY

11. Confirm, at all times, the solution meets MITA standards for SOA and interoperability.

Medicaid Incentive360 has been designed, developed, implemented and operated in conformance with the adopted Medicaid Information Technology Architecture (MITA) standards for Service Oriented Architecture (SOA) and interoperability. The functional scope and operational independence of the EHR Medicaid Incentive Payment Administration Tool does not justify the utilization of an Enterprise Service Bus (ESB) to implement SOA, but it absolutely incorporates the XML standards based interoperability standards as manifested in the CMS NLR interface set.

CGI's Medicaid Incentive360 solution utilizes the n-tier architecture providing the ability to leverage an ESB as the opportunities are encountered during the lifetime of the program.

4.1.12 MONTHLY REPORTS

12. Provide necessary monthly reports, including but not limited to:

a. System Availability and outages.

In the Iowa-hosted option, CGI will work with the State to produce the following statistics and include them in our Monthly State Report:

- ▶ System Availability – 97.5% availability requirement, not including agreed upon scheduled maintenance outages
- ▶ Meeting availability within two business days – 98% of the time
- ▶ Satisfaction rate – 80% based on annual provider surveys conducted by IME

b. Activities completed and planned.

Transparency is a key component of CGI's project management philosophy. In that spirit, our standard practice is to provide weekly status reports to our clients' project management office that provide an accurate detail of how we are performing in accordance with the ratified project plan.

Our standard weekly status report includes, at a minimum, the following:

- ▶ Accomplishments – WBS Tasks Completed (Detailed WBS attached to this report)
- ▶ Tasks Planned for Current Period not Completed
- ▶ Planned Accomplishments for the Next Reporting Period
- ▶ Issues/Concerns
- ▶ Change Requests
- ▶ Milestone Review
- ▶ Revised and Updated Schedule/WBS



4.1.13 HARDWARE, SOFTWARE, SYSTEM SUPPORT FROM THE AGENCY

If the solution is dependent upon hardware, software, or systems support from the Agency, please state that in the proposal.

Exhibit 4-43 presents a description of the hardware and supporting 3rd party software that host and operate CGI's Medicaid Incentive360 application in the Iowa technical environment. These components will be required for the state hosted alternative.

Exhibit 4-43: Summary Hardware and Software Requirements

Technical Component	Description
Operating System	MS Windows 2008
Relational Database Management System (RDBMS)	MS SQL Server 2008
Web Server	Apache Web Server 2.2 with mod_jk plug in openssl plugin for X509 PKI support (HTTPS encryption between browser and application, certificate based client authentication)
Web Server Host	VMs 2 Xeon e5520 processor (4 core per processor, 2.27 GHZ, 8 threads (VM Instance) 8 GB Memory Local disk is 45 GB – additional storage is network
Application Server Host	VMs 2 Xeon e5520 processor (4 core per processor, 2.27 GHZ), 8 threads (VM Instance) 8 GB memory Local disk is 45 GB – additional storage is network
Application Server software	JBoss 5.1 with Tomcat, Hibernate, Struts, Axis SOAP, JAX-RPC, Apache HTTP Client,
Database Server	2 Dell PowerEdge R810 4 - Intel Xeon X5680 48 GB Memory 408 GB (R5) Local Disk Each x5680 is 6 cores @ 3.33 GHZ, 12 threads
Connectivity Software	Connect:Direct, GenTran, SFTP, FTPS, or others as approved
Business Intelligence Software	Jaspersoft Pro Suite 3.7



Technical Component	Description
SAN Storage	1.5 TB
Business Intelligence Suite	Jasper 3.7
Digitally signed PDF documents	iText 5.0.6 from Apache; bcmail-jdk16-143.jar from bouncycastle.org; bcprov-jdk15-1.43.jar from bouncycastle.org
Development platform	Window XP-Pro
Development tools	Eclipse IDE iReports

4.2 PERFORMANCE MEASURES

1. The system will be fully functional by April 2, 2012.

Based on our previous experience and the detailed project plan developed for this project, CGI can meet and exceed the requirement for the State of Iowa’s EHR Medicaid Incentive Payment Administration Tool to be fully functional by April 2, 2012.

2. The contractor will correct Deficiencies within two business days, or as agreed to by the Agency.

CGI will meet the requirement that we correct Deficiencies within two business days, or as agreed upon by the Agency. We look forward to partnering with the State of Iowa in leveraging the premiere Medicaid EHR Incentive solution and joining the states that leads the nation in disbursement of incentive funds.

3. The system will have 97.5% availability. Availability does not include outages as agreed upon for scheduled maintenance activities.

CGI is confident that our hosted, Software-as-a-Service solution will provide at least 97.5% availability, not including outages as agreed upon for scheduled maintenance activities. CGI cannot warrant availability when hosted on non-CGI environments.

4. Given a two business day notice, the contractor will be available for meetings 98% of the time.

The CGI team will be available for meetings with IME and designees 98% of the time given two business days notice.



5. The application will receive a satisfaction rate of 80% or higher on the annual provider surveys conducted by the IME.

Based on experiences and feedback to date, CGI is confident that the Medicaid Incentive360 application will receive a program participant satisfaction rate of 80% or higher on annual provider surveys conducted by IME.

4.3 CONTRACT PAYMENT METHODOLOGY

A payment will be made upon the completion of successful implementation and Agency acceptance. Thereafter, payments will be made during the operational phase on a monthly basis.

CGI agrees to this contract payment methodology.

4.4 DRAFT DOCUMENTS

In addition to addressing the Scope of Work outlined in Section 1.3, bidders must submit the following draft documents behind Tab 4.

CGI has included the following draft documents for Iowa's consideration. Given the page limit requirements of this RFP, we have provided representative sample screen shots and reports for the State's review and consideration.



WORK PLAN



TRAINING PLAN



PROJECT TIMELINE



SCREEN SHOTS



SAMPLE REPORTS



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5 BIDDER'S BACKGROUND

5.1 EXPERIENCE

-Level of technical experience in providing the types of services sought by the RFP.

As we demonstrate in this response, CGI is amply qualified and able to consistently meet and exceed the requirements put forth in this RFP. Leveraging our formidable experience in the health IT market combined with our experience with CMS developing components of the NLR, CGI offers Medicaid Incentive360™, a turnkey end-to-end solution that not only meets but exceeds Iowa's requirements for an EHR Medicaid Incentive Payment Administration Tool. Based on our analysis, **our program meets ALL of the State's requirements out-of-the-box** with very little modification to our existing code base while providing additional features Iowa is sure to find beneficial. Our multi-state program is fully operational in two large Medicaid states and has been in production since January 3, 2011. We are proud to count both the State of Texas and State of Ohio as full program participants.

CGI offers Medicaid Incentive360 a turnkey end-to-end solution that not only meets but exceeds Iowa's requirements for an EHR Medicaid Incentive Payment Administration Tool.

What Makes Us Different

The past 18 months developing and operating our end-to-end multi-state solution has shown us there is no substitute for direct experience. By leveraging CGI's Medicaid Incentive360 solution, the State stands to benefit from our experience to date managing all aspects of our multi-state program. CGI's knowledge of the Medicaid EHR Incentive Program is unsurpassed. We differentiate ourselves from our competitors because our unique experience and qualifications for this program:

- ▶ CGI was **the only vendor** associated with a CMS Group 1 State who led the development and implementation of a solution and met the January 3, 2011 deadline. We attribute this success to our advanced knowledge of the program gained, in part, from our experience working with CMS on components of the NLR for months before the Final Rule was released.
- ▶ CGI was the **first vendor to stand-up and operate an end-to-end business and technical services** for an EHR Provider Incentive Program. CGI's Medicaid Incentive360 program was conceived as a full end-to-end multi-state solution from the program's inception.
- ▶ CGI is the only vendor who offers a turnkey end-to-end state-level solution who has **direct experience developing and supporting components of the NLR** at the federal level. We bring a superior understanding of the complexities of the rules and regulations from both the federal and state perspectives.
- ▶ Currently in our 8th month of full end-to-end operations, CGI currently operates EHR Provider Incentive Programs for **two of the country's largest Medicaid states**. As a result, our system has processed more payments than all of our competitors combined as demonstrated in Exhibit 5-1.



Exhibit 5-1: Payments Processed by Vendor

System Vendor	Payments Processed Through August 2011
CGI	\$159,001,455
HP	\$24,405,818
ACS	\$19,076,177
CNSI	\$1,253,750
CSC	\$467,500
PSI	\$0

Through operating the program on behalf of our participant states, CGI is frequently exposed to unique business scenarios which helps us advance our understanding of the program and streamline our approach to serving the Providers. In fact, CGI routinely encounters scenarios that are not addressed in the Final Rule or the Q&A that we bring to CMS for consideration and joint resolution.

- ▶ **CGI centrally manages the people, processes and technologies** that compose our Medicaid Incentive360 program so that our program knowledge is retained and can be applied from one state to the next. For the Iowa Medicaid EHR Incentive Program project, CGI is proposing our most knowledgeable Medicaid EHR Incentive Program experts who have been with our program since its beginning. While our competitors are having difficulty retaining knowledgeable staff, CGI is proud to offer Iowa the staff that originally conceived and developed our program. This team did not only design and develop CGI’s solution, they also continue to enhance the solution and provide ongoing support for our multi-state program.

Benefits of Our Approach

As a part of our multi-state model, Iowa stands to greatly benefit from CGI's extensive investment to date and our industry-leading knowledge of the many different EHR Incentive Program facets. Conceived as a multi-state offering from its inception, CGI’s solution offers multiple benefits to Iowa:

The Medicaid Incentive360 solution was conceived as a multi-state offering from its inception.

- ▶ **Pooled experience.** Although this program deals with technology, its ultimate goal is to advance the quality and betterment of health outcomes among our nation’s citizens. It has regulations and guidance that require a high degree of interaction with the National Level Repository (NLR) and an intense focus on outcomes data. Only CGI has the depth of experience across a variety of federal and state health initiatives needed to design, build and manage such a diverse program. CGI’s centralized model allows us to pool our health care experience to inform, guide, build, and host while assigning a dedicated local team to meet Iowa’s unique configuration requirements.



- ▶ **Economies of scale.** In accordance with CMS guidance and emphasis on collaboration and reuse, our approach is built on the premise of economies of scale. With CGI's Medicaid Incentive360 program, Iowa will no longer have to shoulder the burden of potentially expensive software development and technical operations costs. For functions and services that are mandated by the final rule and are common across states, a centralized program will be more efficient and will ultimately provide better value.
- ▶ **A future-proof solution.** As the CMS guidance and regulations evolve, so will our solution and services. With a centralized model, CGI can efficiently build the solution and services in accordance with the current guidance and regulations. We will also continue to analyze and implement future guidance and rulings to help keep Iowa compliant for the program's next ten years.
- ▶ **Collaboration through the Medicaid Incentive360 User Conference.** Our participant states actively collaborate and share ideas on how to address the program's requirements and maximize the value to their provider community. Informal communications between states occur frequently. As a part of our multi-state offering, CGI sponsors a Medicaid Incentive360 User Conference that is held in conjunction with the annual MMIS Conference. Participant states agree on the agenda and use this opportunity to discuss and share ideas about the program. This year's conference featured topics such a discussion of the Medicaid Incentive360 product roadmap, client feature requests, and future collaboration strategies.
- ▶ **Reduced implementation risk.** CGI has implemented the Medicaid Incentive360 program for States of Texas and Ohio, two large Medicaid states. Through our implementation and operations experience, we have gained valuable lessons learned from which Iowa will directly benefit. To further reduce the implementation risk, the team members proposed on the Iowa project is the same team that originally built the software and has worked on both the Texas and Ohio projects. With this strong team and approach, Iowa will not have to increase staff nor invest in an expensive software development effort for this time-limited program.
- ▶ **Cost Savings.** First and foremost, all of the efficiencies of CGI's multi-state offering outlined in the previous bullets ultimately lead to desirable cost savings for our program participants. Furthermore, there is no cost to Iowa for the software and documentation that we have already developed on behalf of our Medicaid Incentive360 partner states which includes the solution and approach to fulfill CMS Stage 1 directives. Looking forward to CMS Stage 2 and beyond, Iowa will then be in a position to share future development costs with other Medicaid Incentive360 participants.

Our Qualifications

With CGI, you are engaging **the leading EHR Provider Incentive Program experts.** CGI offers the experience and know-how required to stand-up and operate Iowa's EHR Medicaid Incentive Payment Administration Tool based on an impressive record of qualifications for this program. We have more than 35 years of experience in delivering end-to-end IT and business services to solve complex government challenges. CGI offers the State of Iowa a solution, implementation, and support path that is heads above our competitors. Our best-in-class solution is of the highest quality and is unquestionably the most mature in the marketplace. Our strong relationships with the Centers for Medicare & Medicaid Services (CMS) date back more than a decade, and we have engaged them with our solution and approach since our



program's infancy. We are the only vendor associated with a CMS Group 1 State who led the development and implementation of a solution and met the January 3, 2011 deadline. Since the beginning, our program was carefully and thoughtfully designed as multi-state solution.

Why has CGI been able to do what other vendors have not been able to do?

Because with CGI, you are engaging EHR Incentive Program experts who are solely focused on making our partners successful. We thoroughly understand the complexities of the program and have created a turnkey multi-state solution that addresses all of the program's unique aspects. Most importantly, our program continues to improve with each registration we process, each payment we create, and each Provider we service. There is unquestionably no substitute for experience and we are fortunate to have a program that has been operational since January 3, 2011. Our extensive qualifications for this specific program differentiate us from our competition:

- ▶ CGI is the only state-level EHR Incentive Program vendor with direct experience with the CMS EHR Incentive Program
- ▶ CGI is the first vendor to stand-up an end-to-end multi-state program including the solution, business services and SaaS
- ▶ CGI has broad experience to implement and operate Iowa's EHR Medicaid Incentive Payment Administration Tool
- ▶ CGI has deep industry expertise in Healthcare and Government
- ▶ CGI has demonstrated a deep commitment to Iowa



Direct Experience with the CMS EHR Incentive Program

As of July 2011, our high performance, high volume portal has processed a total of 83,544 provider registrations with that number increasing daily.

Nationally, CGI has an informed perspective and leveraged experience to offer Iowa's EHR Medicaid Incentive Payment Administration Tool from the work that we are performing on behalf of CMS. We have developed and continue to support the central provider registration and attestation components required by the EHR Incentive Program, which provides the front end to the National Level Repository (NLR). As of July 2011, our high performance, high volume portal has processed a total of 83,544 provider registrations with that number increasing daily.

We work with CMS and its contractors on a daily basis on the national initiative and have direct access to the program's key stakeholders. We believe that this combination of knowledge, competence, and relationships gives CGI a uniquely effective position to help states to meet the federal program's interoperability requirements and aggressive timelines. As we work at a national level with the CMS team, we were afforded an early insight into the program's requirements and quickly gained experience and knowledge about the program.

First to Offer An End-to-End Multi-State Offering

When CGI first started planning the Medicaid Incentive360 program over 18 months ago, we started with the basic premise that states would realize the best value through a multi-state offering. While our competition was coming up to speed on solution edits and portal framework, CGI confidently proceeded



with a full end-to-end vision that not only included the technical solution but complimented it with professional business services administered by Program Specialists and full infrastructure support. With every state mandated to adopt the same Federal guidance, we recognized the synergies we could enable through a multi-state offering built on our 35 year experience serving public sector clients through solutions, business process services and technology. In the State of Texas, we were fortunate to find a partner who shared a similar vision from which we were able to build a robust multi-state program skillfully designed from the onset to serve multiple states. With Texas’ full support, CGI became the first vendor to stand-up and operate an end-to-end multi-state program on January 3, 2011. A few weeks after going live, the State of Ohio signed onto the program and was live after a 4 month implementation.

Being first means that CGI has the most mature multi-state program available. Over the last 8 months, our team of consultants and Program Specialists has confidently matured in their knowledge of the program. With steady and planned growth, CGI has been able to nimbly address changing requirements that have surfaced and has refined its implementation and operations approach based on experience. To further quantify our experience, we have included Exhibit 5-2 which provides a summary of all of CGI's Medicaid Incentive360 participant states’ processing statistics as of June 2011.

Exhibit 5-2: CGI's Medicaid Incentive360 Program Highlights

Service Efficiency	
Average # of days from registration to attestation	10
Average # of days to complete an audit	4.5
Number of days needed to make a payment	2
Percentage of calls resolved on first contact (excluding calls related to disputes, audits, and appeals)	96%
Percentage of calls answered in 120 seconds	96%
Volume Processed to Date	
Total Payments Pending	\$78,561,432.23
Total Payments Issued	\$158,958,955.12
Total Payments (Pending + Issued)	\$237,520,387.35
Number of Registrations	3732
Audits Completed to Date	532
Customer Service Inquiries Processed to Date	4021
Outbound Correspondence Delivered to Date	11169

While our direct work with Texas and Ohio began in the last 10 months, CGI had invested months of R&D analysis and planning activities for Medicaid Incentive360 well before engaging with our first



Medicaid Incentive360 client. Exhibit 5-3 depicts the timeline for the formation of CGI's Medicaid Incentive360.

Exhibit 5-3: Timeline for the formation of CGI's Medicaid Incentive360

Event	Date
CGI Delivers NPPES/PECOS/PQRI Systems for CMS	Ongoing
CMS Selects CGI to deliver EHR Incentive Program Registration and Attestation Components	March, 2010
CMS conducts comment period on Meaningful Use Interim Final Rule; CGI completes Medicaid Incentive Program conceptual design, approach and workflow	March, 2010
CGI conducts early State stakeholder meetings to validate design and approach	April – June 2010
CMS issues Final Rule; CGI validates conceptual design and kicks off build process	July 15, 2010
CGI and Texas agree to partner and work begins on defining state specific requirements and NLR interfaces.	August 4, 2010
CGI starts testing with NLR for the State of Texas (date assigned by CMS)	November 10, 2010
CGI formally launches Medicaid Incentive360 for the State of Texas	January 3, 2011
CGI launches State of Ohio's Medicaid Provider Incentive Program into production	June 1, 2011

Broad Experience to Implement and Operate Iowa's EHR Medicaid Incentive Payment Administration Tool

The EHR Incentive Program is a new, first of its kind, multi-faceted program intended to advance health outcomes by using quality data not previously available in a comprehensive electronic reporting format. It is a very bold and transformational objective. To achieve these goals, Iowa will benefit from a flexible partner with a vast breadth of Healthcare IT experience at the state, local and national levels. CGI offers a unique depth of experience across numerous federal and state health initiatives including program management, business process, provider services and custom developed IT solutions. We also have a proven track record of meeting state and federal regulatory requirements with flexible solutions that can be easily modified to address requirements of the future. On a daily basis, CGI collaborates with and advises key government decision-makers who are defining policies, setting direction, and executing innovative health IT programs. We are engaged with many strategic federal initiatives that continuously inform and guide our program.

Exhibit 5-4 illustrates areas of relevant subject matter expertise needed to support Iowa's EHR Medicaid Incentive Payment Administration Tool and examples of CGI's related qualifications.



Exhibit 5-4: Relevant Subject Matter Expertise

Required Subject Matter Expertise	Relevance to Program	CGI's Qualifications
Direct knowledge of Medicare and Medicaid EHR Incentive Programs	Program-wide	CGI has developed the CMS registration portal for both the Medicare and Medicaid Incentive Programs as well as implemented the Medicare attestation portion of the program. This portal is the front-end to the National Level Repository (NLR). We have also designed, built and implemented state-level EHR Incentive solutions for the State of Texas and the State of Ohio.
Participation in National HIT Initiatives	Registration and Attestation; Interoperability and Exchange	CGI has delivered major enterprise programs including Medicare.gov website, Medicare Appeals System for secondary appeals, National Plan and Provider Enumeration System (NPDES), and Provider Enrollment Chain and Ownership System (PECOS) CGI is an early and ongoing participant in the NHIN trials and connect-athons. Recently, CGI was awarded a contract with the FHA to provide support the CONNECT Nationwide Health Information Exchange (NHIE) Gateway Solution and evolve the technology into a robust open source solution that supports secure, standards-based health information exchange and “meaningful use” of health information technology.
Understanding of Quality Data	Quality Measures, Interoperability and Exchange	CGI is involved in the Physician’s Quality Reporting Initiative (PQRI) program and has conducted a new pilot for the program performing electronic submission of quality data over the NHIN in conjunction with three community HIEs.
Understanding of Medicaid Claims Data	Payment Calculation; Business Process Services	CGI understands Medicaid claims data through our work with the State of Colorado Medicaid Claims portal, CGI’s Medicaid Audit work with the State of Pennsylvania, CGI’s work as the Medicare RAC program for Region B, and MMIS implementations in California and Massachusetts. Recently, CGI was awarded the contract to perform as Ohio’s Medicaid Recovery Audit Contractor (RAC).
Experience building high-visibility and availability portals in the health IT domain	Portal and Interface Technology; Infrastructure Management; Business Process Services	CGI has built and supports several high-visibility health IT portals such as Medicare.gov; CMS.gov, FederalReporting.gov, and the State of Colorado Medicaid Provider Portal.

Exhibit 5-5 summarizes CGI's broad experience across federal and state organizations that directly qualifies CGI to configure support and operate the Iowa EHR Medicaid Incentive Payment Administration Tool.

Exhibit 5-5: CGI's Qualifications for Configuration, Support and Operations of the Iowa EHR Medicaid Incentive Payment Administration Tool

- State of Texas Medicaid Incentive360
- Ohio Medicaid Provider Incentive Program
- National Level Repository (NLR) Registration and Attestation Components for EHR Incentive Program
- National Plan and Provider Enumeration System (NPPES)
- Provider Enrollment, Chain and Ownership System (PECOS)
- Medicaid Appeals System (MAS)
- Center of Medicare and Medicaid Services (CMS) Web sites
- Medicare Recovery Audit Contractor (RAC) for Region B
- Physician Quality Reporting Initiative (PQRI) Electronic Health Record NHIN Concept of Operations
- Federal Reporting.gov
- State of Colorado Medical Assistance Program Secure Web Portal
- Commonwealth of Pennsylvania Department of Public Welfare (DPW), Office of Medical Assistance Programs Medicaid Audit
- State of California - California Medicaid Management Information System (CA-MMIS)
- Commonwealth of Massachusetts NewMMIS
- Commonwealth of Iowa Health Information Exchange Strategic and Operational Planning
- Commonwealth of Iowa eVA, Iowa's Electronic Procurement Solution
- Commonwealth of Iowa Department of Taxation Partnership Project
- Housing and Urban Development Contract Management and Consulting
- State of Louisiana Road Home

Deep Industry Expertise in Healthcare and Government

CGI believes in implementing technology that transforms client business environments. That is why we offer services within focused industries where we have developed deep domain expertise and can partner with our clients to anticipate and deliver solutions that address ever changing industry norms. Two areas critical to Iowa's program success, public sector and healthcare, are primary areas of focus for CGI, representing 60% of our total U.S. business revenue. For 35 years, CGI has brought innovations and transformational solutions to our public sector and healthcare clients. Our client experience includes:

- ▶ 90% of U.S. state governments and 75% of Canadian provinces
- ▶ 3,000+ local governments, including more than 70 of the 100 largest counties
- ▶ A majority of U.S. and Canadian federal government agencies and departments

CGI is a proven leader in the health IT market as well, as acknowledged by industry analysts. CGI has more than 16 years of experience working on large-scale health system integration and development efforts in both the public and private sector, including:

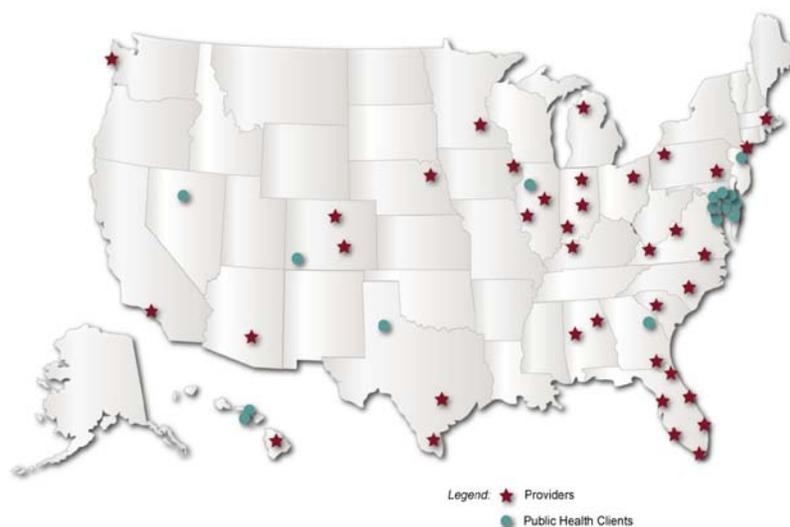
- ▶ 38 healthcare systems and 225 hospitals and departments of health
- ▶ 50% of the U.S. Blue Cross Blue Shield plans
- ▶ More than 10 strategic projects with U.S. Department of Health and Human Services

CGI harnesses the power of technology to improve the quality of care, while managing costs and enhancing productivity. We focus on services and solutions that deliver immediate and measurable value. We also manage critical IT and back-office functions on behalf of clients, allowing organizations to focus on what matters most—providing high-quality care. Additionally CGI provides industry leading content management and application service provider (ASP) solutions which are used in over 225 hospitals across North America.

CGI's focused healthcare practice has a team of hundreds of professionals including a number of clinical professionals who can be drawn upon to support implementation projects—i.e., physicians, pharmacists, nurses, chiropractors, and health information management professionals. We also provide consulting services, large application development and application management services to many government departments of health across the U.S. and internationally.

Exhibit 5-6 represents a snapshot of CGI's healthcare experience in the U.S., including the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), Jewish Hospital and St. Mary's Healthcare, Commonwealth Health Corporation (Kentucky), Illinois Department of Public Aid, Hawaii Department Of Health, Merck Medco, California Department of Health Services, Memorial Hermann Healthcare System, and Carillion Clinic, among others.

Exhibit 5-6: CGI Healthcare Experience in U.S.





During the past decade, we have delivered electronic health solutions to more than 500 hospitals, health systems, clinics, and health information exchange organizations, as well as health insurers, managed care organizations and government payers worldwide. Through these partnerships, we have developed an understanding of the industry and its supporting technology and we have demonstrated a proven track record of successful implementations. Our industry best practices and well tested processes will be leveraged for the same success in Iowa. This experience is complemented by our over 10 years of working on Medicaid-related systems and support for clients such as the State of California and the Commonwealth of Massachusetts. Our clients tell us that they are consistently impressed with the quality of our consultants and their demonstrated knowledge of the required subject matter area.

CGI has consistently received industry accolades and awards for our accomplishments in the healthcare industry. Among them is our work designing and developing the CMS Websites received both Gold and Silver 2008 eHealthcare Leadership awards and a 2008 WWW Health award. In addition, Health 2.0 selected CGI as the 2010 winner of its Challenge for Consumer Apps to Visualize Healthcare Quality Measures. The challenge, supported by the U.S. Department of Health and Human Services, was designed to spur innovation in creating easy-to-use applications to help Americans make decisions about their healthcare.

Deep Commitment to Iowa

CGI has been an IT partner with the State of Iowa for over 20 years. This partnership dates back to the 1980's when Iowa implemented CGI's financial management system on a statewide basis. Eventually, this system was upgraded in 2002, renamed I/3, and continues to support statewide administrative management needs through a partnership between CGI and the Iowa Department of Administrative Services.

Similarly, starting in the 1980's, the State has operated CGI's computer-assisted collection system (CACCS-G) for the management of tax revenue collections, and continues to modernize and improve its collection processes through a partnership between CGI and the Iowa Department of Revenue.

These collaborations have afforded CGI the opportunity to apply our integration skills to successfully implement mission-critical applications and provide value to the State of Iowa. Importantly, these have also allowed CGI to form partnerships with the respective agencies that have stood the test of time. In both cases, periodic modernization efforts have been undertaken that have allowed the State to derive operational improvements when new technologies and best-practices have emerged; and in both cases, CGI continues to be asked to deliver through our partnership to provide these results.

Iowa's EHR Medicaid Incentive Program is another endeavor where an IT vendor must be selected who can be trusted to deliver on the promise of technology through a trusted partnership alliance. CGI has a commitment to Iowa and has demonstrated our ability to succeed in delivering technology to derive operational improvements for the State of Iowa.



5.2 SIMILAR SERVICES

-Description of all services similar to those sought by this RFP that the bidder has provided to other businesses or governmental entities within the last twenty-four (24) months.

For each similar service, provide a matrix detailing:

- Project title;*
- Project role (primary contractor or subcontractor);*
- Name of client agency or business;*
- Start and end dates of service;*
- Contract value;*
- General description of the scope of work;*
- Whether the services were provided timely and within budget; and*
- Contact information for the client's project manager including address, telephone number, and electronic mail address.*

Medicaid Incentive360 was designed and built as a multi-state offering and we are proud to count both the State of Texas and the State of Ohio as program participants. Iowa can realize tremendous value by taking advantage of a multi-state model that is in line with CMS' directive to states to look for opportunities to foster collaboration, reuse, and cost sharing. There is no cost to Iowa for the software and documentation that we have already developed on behalf of our Medicaid Incentive360 partner states which includes the solution and approach to fulfill CMS Stage 1 directives. Looking forward to CMS Stage 2 and beyond, Iowa will then be in a position to share future development costs with Medicaid Incentive360 participants. As previously mentioned, CGI's foundational knowledge of the EHR Incentive Program was garnered through our experience with design, development, and ongoing support of the National Level Repository (NLR) Registration and Attestation Components for EHR Incentive Program.

To best demonstrate CGI's experience and capacity to deliver high quality services to Iowa, we have selected these 3 (three) most highly relevant corporate experiences which are substantially similar to Iowa's proposed scope of work. Each of these projects reflects CGI's in-depth knowledge of the EHR Incentive Programs, our capacity to deliver, our commitment to quality, and our ability to meet aggressive timelines. These projects are meeting and often exceeding objectives through the implementation of the same project methodologies we are proposing for Iowa:

- ▶ State of Texas Medicaid Incentive360
- ▶ State of Ohio Medicaid Provider Incentive Program
- ▶ National Level Repository (NLR) Registration and Attestation Components for EHR Incentive Program



State of Texas Medicaid Incentive360

Project Title	State of Texas Medicaid Incentive360
Project Role (primary contractor)	Lead contractor in terms of project implementation and operations Contractually, a subcontractor



or subcontractor)	
Name of Client Agency or Business	Texas Health and Human Services Commission
Start and End Dates of Service	October 2010 – Present
Contract Value	For Texas Medicaid Incentive360, CGI is working as a directed sub-contractor to the State's MMIS vendor. The cost to Texas for the full Medicaid Incentive360 program (including prime contractor fees, software build, program management, business services and technical services) is \$8,361,712 over a 23 month contract period. This includes the Primary contractor's overhead to administer the contract.
General Description of the Scope of Work	<ul style="list-style-type: none"> ▪ Development and implementation of Medicaid Incentive360 software for CMS Stage 1 including project management, design, development, testing, documentation, communications support, and training. ▪ Business Services including Customer Service Center, Policy and Procedure Management, Audit and Appeals Processing Services, Communications support, and Ad Hoc Reporting Services ▪ SaaS including hosting, application management, infrastructure management, disaster recovery
Whether the services were provided timely and within budget	Yes
Contact information for the client's project manager including address, telephone number, and electronic mail address	Yvonne Sanchez Texas Health and Human Services Commission Brown-Heatly Building 4900 N. Lamar Blvd. Austin, TX 78751-2316 512-491-4055 Yvonne.Sanchez@hhsc.state.tx.us

CGI has successfully implemented and currently operates Medicaid Incentive360 for the State of Texas, an NLR Group 1 CMS test state. The solution is a “stand alone” EHR Incentive Payment system meaning that it was developed to interface and integrate with every major MMIS in the market and is not dependent on any one solution in particular. The system successfully went live on January 3, 2011. CGI, in representation of Texas, is actively engaged in the weekly CMS calls, has access to all of the CMS documentation, and is fully immersed in the program. We have harnessed a strong team with a deep understanding of the CMS rules and guidance and have hands-on experience building our Medicaid Incentive360

Primary Relevance to Iowa

- ▶ Iowa will directly benefit from our experience successfully implementing and operating Medicaid Incentive360 for an NLR Group 1 CMS test state.
- ▶ Iowa will quickly and efficiently meet program compliance without undue risk, burden or cost
- ▶ State-of-the-art, configurable solution is a “stand alone” EHR Incentive Payment system.



solution which meets all of the program requirements. Iowa will no doubt benefit from the solution that CGI has built and the experience that CGI has gained to date.

CGI's scope of work for Texas includes program management, business services, and technical services (both the development of the software and the hosting of the technology) which comprise the Medicaid Incentive360 end-to-end solution. The State of Texas adopted an implementation schedule with three releases with the first release divided into two sub-releases. Iowa will receive the software for all three releases. Exhibit 5-7 lists the specific software components that CGI has been contracted to develop for the State of Texas along with the agreed-upon implementation dates for the State of Texas.



Exhibit 5-7: Software Components Contracted to Develop for the State of Texas

Release	Scope	State of Texas Implementation Date
Release 1A	<ul style="list-style-type: none"> ▪ Federal B6, B7, D16, and D18 Interfaces ▪ Federal batch error Interfaces ▪ State Provider Demographic Interface (provider crosswalk) ▪ State Payment Denial Code (PDC) web service ▪ Provider Crosswalk ▪ Initial Provider email Communication (B6 found/not found) ▪ Dashboard ▪ Reports: Provider Activity Report 	January 3, 2011
Release 1B	<ul style="list-style-type: none"> ▪ Provider Profile Interfaces (patient volumes) ▪ Provider Portal Infrastructure and Local Authentication ▪ Account Management ▪ Document Management ▪ Enrollment ▪ Status ▪ State Portal ▪ System Help and FAQ functionality ▪ Provider Appeal functionality ▪ Reports: Registration Summary Report, Attestation Summary Report, Dispute and Appeals Activity Report, Provider Dispute Report, Provider Assignment Report 	February 15, 2011
Release 2	<ul style="list-style-type: none"> ▪ Distribution of applicable payments amounts for eligible providers ▪ Tracking of provider payment amounts by NPI/CMS Certification Number from year to year ▪ Tracking assignment and change of assignment by NPI ▪ Ability to allow eligible providers to check the status of their incentive payments and payment history using the attestation portal. ▪ Reports: Payment Summary Report, Audit Activity Report, Provider Audit Report, Provider Dispute Report ▪ System processes support provider appeals including escalation to HHSC HIT Program. 	April 1, 2011



Release	Scope	State of Texas Implementation Date
Release 3	<ul style="list-style-type: none"> ▪ Collection through attestation and the NLR EHR Stage 1 meaningful use data including: <ul style="list-style-type: none"> – Ability to collect federally and state required meaningful use and clinical quality measures. – Ability to view meaningful use aggregate data submitted by the EP / EH. ▪ Aggregated Meaningful Use Data Report 	January 1, 2012

State of Ohio Medicaid Provider Incentive Program (MPIP)



**Department of
Job and Family Services**

Project Title	State of Ohio Medicaid Provider Incentive Program (MPIP)
Project Role (primary contractor or subcontractor)	Primary Contractor
Name of Client Agency or Business	Ohio Department of Jobs and Family Services
Start and End Dates of Service	January 2011 – Present
Contract Value	\$4,808,900
General Description of the Scope of Work	<ul style="list-style-type: none"> ▪ Development of select enhancements and implementation of Medicaid Incentive360 software for CMS Stage 1 including project management, design, development, testing, documentation, communications, and training. ▪ Business Services including Help Desk Call Center, Policy and Procedure Management, and ongoing Communications and Training support. ▪ SaaS including hosting, application management, infrastructure management, disaster recovery
Whether the services were provided timely and within budget	Yes



Contact information for the client's project manager including address, telephone number, and electronic mail address	Mark Vidmar Ohio Department of Jobs and Family Services Lazarus Building Downtown 50 W. Town Street Columbus, OH 43215 (614) 752-4395 mark.vidmar@jfs.ohio.gov
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The State of Ohio contracted with CGI through competitive procurement to implement and support their Medicaid Provider Incentive Program based on CGI's Medicaid Incentive360 solution. With a goal of standing up a state-of-the art solution by June 1, 2011 or sooner, Ohio recognized the value of leveraging a proven solution that was already built to meet federal rules and guidance, working with a vendor who has deep knowledge of the program, and lessening the dependency on their MMIS provider. The Fit-Gap analysis of the Medicaid Incentive360 solution against Ohio's requirements revealed an 85% fit. Therefore, Ohio funded 14 modifications to the system to meet their unique needs. Ohio was placed in the NLR drop down on May 2nd and went live with the solution on June 1, 2011. CGI's commitment to delivering the Ohio solution by the June 1st never wavered. Our ability to stay on track was due to the commitment of our experience Medicaid Incentive360 solution, their experience building the solution for Texas, and our ability to quickly move through the NLR testing with CMS.

Primary Relevance to Iowa

- ▶ In depth understanding of the EHR Incentive Program regulations
- ▶ Hands-on experience implementing State of Texas software and other technical components in another state.

In addition to providing the services to implement the solution, Ohio has contracted with CGI to provide ongoing technical help desk support and infrastructure hosting. Lastly, CGI provided extensive Communications Management support developing Provider communications, website material, FAQs, tip sheets, and supporting the rollout of live webinars training up to 500 potential eligible providers on how to use the system.

Centers for Medicare & Medicaid Services (CMS) - National Level Repository (NLR) Registration and Attestation Components for EHR Incentive Program



Project Title	National Level Repository (NLR) Registration and Attestation Components for EHR Incentive Program
Project Role (primary contractor or subcontractor)	Primary Contractor
Name of Client Agency or Business	Centers for Medicare & Medicaid Services (CMS)
Start and End Dates of Service	March 2010 – Present
Contract Value	\$5,000,000



General Description of the Scope of Work	Design, development, implementation and operational support for the EHR Incentive Program Portal for Medicare and Medicaid including registration and attestation components
Whether the services were provided timely and within budget	Yes
Contact information for the client’s project manager including address, telephone number, and electronic mail address	Paige Falk Centers For Medicare & Medicaid Services 7500 Security Blvd, Baltimore, MD 21244 401-786-1437 paige.falk@cms.hhs.gov

Nationally, CGI has an informed perspective and leveraged experience to offer Minnesota Medicaid EHR Incentive Program from the work that we are performing on behalf of CMS. We have developed, implemented and now support the central provider registration and attestation components required by the EHR Incentive Program, which provides the front end to the National Level Repository (NLR). We work with CMS and its contractors on a daily basis on the national initiative and have direct access to the program's key stakeholders. We believe that this combination of knowledge, competence, and relationships gives CGI a uniquely effective position to help states to meet the federal program’s interoperability requirements and aggressive timelines.

CMS is responsible for implementing the Federal-level Health Information Technology for Economic and Clinical Health Act (HITECH) incentive payment provisions. At the core of CMS’ HITECH project management of a centralized service that will register Medicare and Medicaid participants for the EHR Incentive Program. CGI developed the central provider registration and attestation components required by the EHR Incentive Program which provides the front end to the National Level Repository (NLR):

- ▶ **Registration** - CMS must provide a mechanism for Medicare and Medicaid Eligible Professionals (EPs) and Hospitals to register for the incentive payment program at the Federal level. CGI has built the first level database and providing a web application for providers who are interested in registering for either the Medicare or Medicaid incentive program.
- ▶ **Attestation** - CMS must collect and analyze information from Eligible Professionals and Eligible Hospitals to determine eligibility for the incentive payments for both Medicaid and Medicare. CGI has built web applications to collect attestations from all Medicare Eligible Professionals and Eligible Hospitals. State Medicaid agencies play a complimentary role in managing the processes for Medicaid EPs and EHs at the state level.

Primary Relevance to Iowa

- ▶ In depth understanding of the EHR Incentive Program regulations
- ▶ Hands-on experience delivering software and other technical components associated with program.
- ▶ Experience with high visibility and mission critical HITECH initiative.

CGI is intimately familiar with directly related systems, specifically National Plan and Provider Enumeration System (NPPES) and Provider Enrollment Chain and Ownership



System (PECOS). The new Registration and Attestation modules are associated with NPPES (CGI built and supports NPPES) to take advantage of NPPES' existing capabilities. In addition, PECOS (another application built and supported by CGI) will support validations of Medicare registrations using its database, the Master Death File (MDF), and Medicare Exclusion Database (MED).

The NLR Registration and Attestation project is another example of CMS and CGI continued collaboration to deliver highly visible critical applications in support of the CMS mission.

5.3 OTHER RELEVANT EXPERIENCE

The EHR Provider Incentive Program is a new, first of its kind, multi-faceted program intended to advance health outcomes by using quality data not previously available in a comprehensive electronic reporting format. It is a very bold and transformational objective. To achieve these goals with an extremely aggressive timeframe, Iowa will benefit from a flexible partner with a vast breadth of Healthcare IT experience at the state, local and national levels. We believe CGI offers a unique depth of experience across numerous federal and state health initiatives including program management, business process, provider services and custom developed IT solutions. We also have a proven track record of meeting state and federal regulatory requirements with flexible solutions that can be easily modified to address requirements of the future. CGI is prepared to meet Iowa's aggressive program milestones and has successfully achieved such deadlines in highly visible programs like this one. On a daily basis, CGI collaborates with and advises key government decision-makers who are defining policies, setting direction, and executing innovative health IT programs. We are engaged with many strategic federal initiatives that continuously inform and guide our program.

Our extensive qualifications for this specific program substantially differentiate us from our competition. We have carefully detailed all of CGI's directly relevant qualifications and demonstrated how these qualifications will directly benefit Iowa.

Centers for Medicare & Medicaid Services (CMS) - National Plan and Provider Enumeration System (NPPES)

Pursuant to HIPAA regulations requiring the assignment of a unique identifier to healthcare providers, CMS engaged CGI to design and build a national enrollment system known as the National Plan and

NPPES is a congressionally mandated system developed and implemented by CGI.

Provider Enumeration System (NPPES). NPPES is an application and database that supports the implementation of the NPI (National Provider Identifier) and was a congressionally mandated system developed and implemented by CGI. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gave CMS the responsibility to assign each provider in the country a unique National Provider Identifier (NPI) in order to simplify electronic transactions throughout the healthcare industry. This identifier is required for participation in Medicare and, with some limited exceptions, in Medicaid. NPPES issues

NPIs based on applications submitted via the web, paper, or electronic file interchange (EFI). Individual providers can submit their application via the Web-based system. Organizations can submit application requests via EFI which allows the processing and enumeration of several NPIs from one input file.



NPPES is an in-production, high volume- high performance system with 1.3 million users and thousands of concurrent users. All CGI work on this project was performed within contracted budgeted funding limits and within contracted delivery schedules.

Through the NPPES project, CGI earned its reputation for being the "go to" partner for creative mission critical solutions that achieve tangible results. CMS contracted CGI to build the NLR Registration and Attestation because of CGI's excellent track record of designing and developing NPPES. CGI proved itself to be a flexible and committed partner that focuses on delivering results within aggressive timeframes.

Primary Relevance to Iowa

- ▶ In depth understanding with one of the underlying foundational systems for the EHR Incentive Program and the NPI
- ▶ Ability to meet aggressive timeframes from design, development, and implementation within budget
- ▶ Practical experience building HIPAA-compliant applications



Centers for Medicare & Medicaid Services (CMS) - Provider Enrollment, Chain and Ownership System (PECOS)

PECOS (Provider Enrollment, Chain, and Ownership System) is the vehicle for electronically collecting, relating, and storing Medicare Part A and Part B provider enrollment information in a national database. This web-based application supports the online entry of provider enrollment applications. Once a provider has obtained their NPI, they must enroll in PECOS to participate in the Medicare and/or Medicaid programs. CMS has mandated that the Medicare Administrative Contractors use the CMS Form 855 to capture and verify information relating to provider enrollment in the Medicare program. PECOS supports the Medicare provider enrollment process by capturing information from the CMS-855 forms submitted by providers to CMS' fee-for-service contractors and electronically storing this information in a central national database. PECOS validates the information from several sources (including SSA, NPDES and Finalist) and the PECOS provider records are then used by the Medicare Part A and Part B claims processing systems to update their provider files. Provider files are an integral part of the claims receipt and payment processes. The standardized and validated PECOS provider data has introduced transparency into Medicare billings, resulting in increased fraud detection and prevention. PECOS also provides a logging and tracking function, a chain home office enumeration process, and an inquiry/reporting capabilities. PECOS Web offers providers the ability to enroll in the Medicare program, update existing records, and check the status of electronically submitted applications all via the internet.

Primary Relevance to Iowa

- ▶ In depth understanding with one of the underlying foundational systems for the EHR Incentive Program
- ▶ Ability to meet aggressive timeframes from design, development, and implementation within budget
- ▶ Practical experience building HIPAA-compliant applications

Centers for Medicare & Medicaid Services (CMS) – Medicare Appeals System (MAS)

The Medicare Appeals System (MAS) is a high-profile initiative that transformed the way CMS and its contractors process Medicare appeals. CGI designed, developed and implemented a system to support the legislatively and judicially mandated Medicare appeals process.

MAS is a centralized flexible case management system that provides support for over 16 organizations that tracks the timely and consistent rendering of over a million appeal decisions. It interfaces and exchanges data from other CMS or contractor systems. MAS retains historical information for each appeal and uniquely identifies appeals and associated case records at each level within the appeal hierarchy. Pre-defined and ad-hoc reports can be generated by the various users and administrative owners of the system. These reports are used to identify issues with timeliness, particular plans, or beneficiary groups. MAS provides a centralized system with flexible business process that provide workflow management, CMS oversight, reduction in paper, and increased business intelligence. CGI implemented the MAS application in 10 months.

Within 6 months of implementation, the average number of days to adjudicate appeals fell dramatically from upwards of 1 year to 90 days - and has steadily decreased further to 42 days.



Leveraging best practices in call center business processes, CGI has successfully operated the MAS call center since May of 2005 supporting more than 1,000 users. Within six months of implementation, the average number of days to adjudicate appeals fell dramatically from upwards of 1 year to 90 days and since has steadily decreased further to 42 days. MAS is designed with the flexibility to meet continually evolving federal mandates and effectively comply with the Health Insurance Portability and Accountability Act (HIPAA) and other federal data privacy mandates.

Centers for Medicare & Medicaid Services (CMS) Websites

For the CMS websites project, CMS wanted a partner who effectively understood and supported its overall mission: to provide effective, up-to-date healthcare coverage information to its beneficiaries, caregivers, advocacy groups, and other healthcare industry stakeholders and promote quality care through its high visibility websites. CGI not only understood CMS' vision but also embraced the opportunity to build CMS' public web presence as a vehicle for achieving transparency. The websites empowers beneficiaries and caregivers to use quality and cost information to make more informed health-care choices. In doing so, the tools also stimulate market forces and provide incentives for high-quality performance by healthcare providers.

During our partnership with CMS, CGI helped to evolve the websites - www.medicare.gov, www.mymedicare.gov, and www.cms.hhs.gov - from a basic Web presence to a set of complementary enterprise portals, critical to CMS' mission of outreach, education, and consumer empowerment. The sites have evolved from static and informational to dynamic, transactional, and personalized. Linear, search-oriented tools have become intricate decision support tools comprised of multiple workflows based on user-specified input. As the level of functionality on the sites has increased, the number of page views has grown by a factor of forty, now helping over 500 million visitors per year get the information they need about Medicare. The evolution of the sites enabled CMS to meet challenges

The CMS Websites are consistently recognized with industry accolades and awards, including Gold and Silver 2008 eHealthcare Leadership awards and a 2008 WWW Health award.

including legislative mandates and operational changes and demands from an increasingly sophisticated and rapidly growing user base. The CMS Websites demonstrate CGI's ability to incorporate the latest technology into our products and services which will be an asset to the Virginia Medicaid Provider Incentive Program.

The CMS websites are consistently recognized with industry accolades and awards, including Gold and Silver 2008 eHealthcare Leadership awards and a 2008 WWW Health award.

Primary Relevance to Iowa

- ▶ Ability to build a centralized repository of information that is used for outreach and education.
- ▶ Demonstrated know-how to adhere to a development methodology that enables us to support multiple releases in compressed timeframes despite evolving policy decisions and legislative mandates.
- ▶ Proven ability to leverage technology to build a public facing, high visibility provider outreach and communications solution.

Centers for Medicare & Medicaid Services (CMS) - Recovery Audit Contract (RAC) for Region B

The Centers of Medicare and Medicaid Services awarded CGI the Recovery Audit Contract (RAC) for the Midwest region in October 2008. The goal of the contract is to identify and recover improper payments in the Medicare program. The CGI contract covers seven states and 8.5 million covered lives or 20% of the total Medicare insured population. CGI's engagement as a Recovery Audit Contractor (RAC) for the Midwest region focuses on the following objectives:

- ▶ Outreach and education to providers
- ▶ Identification of improper Medicare payments through automated and complex reviews
- ▶ Recovery of overpayments
- ▶ Coordination with other Medicare contractors and clear communication of audit findings to Providers

Primary Relevance to Iowa

- ▶ Demonstrates CGI's expertise in fraud, waste, and abuse detection and the recovery of overpayments

Centers for Medicare & Medicaid Services (CMS) Office of Clinical Standards and Quality (OCSQ) Physician Quality Reporting Initiative (PQRI) Electronic Health Record NHIN Concept of Operations

Primary Relevance to Iowa

- ▶ Demonstrates CGI's understanding of health information connectivity standards and knowledge of clinical quality data that will be utilized in the development of the Stage 2 electronic reporting requirements for the Virginia EHR Provider Incentive Program

In response to the Tax Relief and Health Care Act of 2006, CMS has developed and implemented a “pay for performance” model to improve the quality and cost effectiveness of services provided to Medicare beneficiaries. CMS has titled this statutory program the Physician Quality Reporting Initiative (PQRI). This initiative provides a bonus payment on addition to the claim payments received. The bonus payment is tied to their compliance with supplying quality data and measures within their claims submissions to CMS.

CMS is facilitating this endeavor through the collection of information about the outcome of services rendered on submitted Medicare claims that have had CPT and HCPCS Quality Data codes populated by the Provider. These codes are then used to compute analytical statistics (i.e. ratios) for Provider feedback reports.

CGI's engagement is comprised of a multi-phase effort. Phase 1 (Steps 1 and 2) involved installing a CONNECT Gateway at the OCSQ infrastructure and demonstrating document exchange with a foreign gateway. Phase 2, now in progress, involves updating the gateway to the CONNECT Gateway and establishing connectivity to an actual Electronic Medical Records (EMR).



FederalReporting.gov

CGI had only a few weeks to build and deploy FederalReporting.gov

FederalReporting.gov is a centralized web-based portal for award recipients to access and fulfill their reporting obligations as defined by the American Recovery and Reinvestment Act (ARRA). This high visibility and high stakes initiative required CGI to deliver a mission-critical solution within an extremely aggressive timeframe.

In fact, CGI had only six weeks to build and deploy FederalReporting.gov. Moreover, CGI successfully established and trained a call center staff and developed training materials for federal agencies and recipients that would be using the site in that timeframe.

The intuitive portal provides recipients and federal agencies with the ability to:

- ▶ Expediently register for the site and manage their account(s) via authenticated security
- ▶ Submit required reports via a user-friendly interface
- ▶ View and comment on reports if the user represents a Federal agency or prime recipient
- ▶ Update or correct reports when appropriate
- ▶ Utilize rule-based workflow to submit, review and accept reports

FederalReporting.gov was built with flexibility and rapid user-adoption in mind. Unlike other governmental reporting systems, FederalReporting.gov had to be able to accept data from not just states and industry but also from mid-sized corporations, universities and even mom-and-pop-type businesses. The system, therefore, had to be understandable to a wide array of users and stakeholders with differing levels of computer and online skills. CGI designed and built a host of capability-rich features such as providing the recipients of Recovery Act funding the ability to enter information into the system through the use of a self-service online interface, uploading XML, or uploading an Excel spreadsheet. In addition, CGI developed a robust help feature and user online help (FAQ) to support the users in the independent navigation and uptake of the system.

In addition to providing continuous application enhancements and support, CGI provides hosting and infrastructure services for FederalReporting.gov as well as maintaining a high volume, program-based call center. Our call center provides support to inbound calls, email, manual correspondence and chat.

State of Colorado Medical Assistance Program Secure Web Portal

The Department of Health Care Policy and Financing, State of Colorado, administers the Medicaid and Child

Primary Relevance to Iowa

- ▶ Highlights CGI's experience in building robust business intelligence and reporting capabilities and intuitive user-friendly portals
- ▶ Shows that CGI has the knowledge and expertise to maintain a program-based call center
- ▶ Ability to work effectively within the complex multi-vendor, multi-stakeholder, highly visible and politically charged environment
- ▶ Underscores CGI ability to produce quality results given extremely short timeframes.

Primary Relevance to Iowa

- ▶ Highlights our ability to transform, build and operate a secure, HIPAA-compliant statewide Medicaid portal for providers



Health Plan Plus programs as well as a variety of other programs for low-income families, the elderly and persons with disabilities. In May 2003, the State needed to implement a web application, improve functionality and replace non-compliant software for the more than 20,000 Medicaid providers and other billing agents so that they could easily submit HIPAA-compliant transactions and other requests.

CGI leveraged its extensive knowledgebase of the Medicaid provider claims submission process and in-depth technology skills required to develop and maintain a HIPAA compliant secure web portal. The provider web portal and application provides a successful value-added service for the Medicaid providers. In 2009, over 9.2 million transactions were submitted through the portal; 5.98 million transactions were submitted to verify Medicaid eligibility. The average response time was 13 seconds, well below the 60 second threshold, and the average success rate was 98%, demonstrating system availability and uptime.

Commonwealth of Pennsylvania Department of Public Welfare (DPW), Office of Medical Assistance Programs Medicaid Audit

The Commonwealth of Pennsylvania's Medicaid Program known as the Medical Assistance (MA) Program, enrolls healthcare providers who render services to eligible individuals. The Office of Medical Assistance Programs (OMAP) wanted assistance to augment the work of the Bureau of Program Integrity (BPI), and both parties needed outside assistance to develop an audit strategy for inpatient services for the next three years and beyond. In short, the client wanted to engage a company to provide services for auditing hospital-based services including inpatient, outpatient and professional claims to determine if they were reimbursed properly according to MA regulations. CGI's experienced and credentialed clinical auditing team proved to be exactly what DPW needed.

Primary Relevance to Iowa

- ▶ Demonstrates CGI's understanding of Medicaid claims data
- ▶ Highlights our deep knowledge of how to design systems that support the audit process and the identification/ collections of over-payments

Over the past three years, CGI has helped Pennsylvania identify more than \$59 million in recoveries for recoupment and has successfully recouped over \$40 million in recoveries. Additional benefits include:

CGI has helped Pennsylvania identify more than \$59 million in recoveries for recoupment and has successfully recouped over \$40 million.

- Automation of the process of offset adjustment of provider overpayments through an interface of CGI's Customized Audit System (CAS) and DPW's MMIS vendor.
- Enhanced provider relations and minimized provider burden through a CGI operated and managed Provider Call Center.
- Monthly administrative reports that provide the DPW with documented results of the audit process.

By working with CGI's qualified and certified medical and audit personnel, BPI is able to effectively audit its claims, analyze payments and recover identified overpayments.



State of California - California Medicaid Management Information System (CA-MMIS)

The California Medicaid Management Information System Fiscal Intermediary contract, effective May 1, 2010, was awarded to the Medi-Cal Business Partnership team led by ACS to whom CGI is a major subcontractor. ACS knew that to displace the seasoned incumbent, they needed to differentiate themselves to the State of California. Therefore, ACS selected CGI because of our rigorous Project Management Office (PMO) discipline and industry-leading quality processes. ACS' strategy proved to be successful. As a major subcontractor, CGI is responsible for the Enterprise Project Management Office, the Quality Management Office, and testing of the legacy and replacement systems through the contract term and extensions. In addition, CGI is leading the automated portion of the Business Rules Extraction effort, is responsible for implementation of its proprietary CACS-G collections application, and for Business Change Management.

Primary Relevance to Iowa

- ▶ Highlights that CGI has an excellent reputation amongst our partners and competitors for having a disciplined and focused approach to project management, quality management, and change management.
- ▶ Demonstrates CGI's strong software development and systems integration capabilities, and comprehensive knowledge of Medicaid claims data and processing.



Commonwealth of Massachusetts - NewMMIS

The Commonwealth of Massachusetts, Executive Office of Department of Health and Human Services (EOHHS) Medicaid program covers roughly 1 million people in Massachusetts processing approximately 75 million claims annually representing benefit payments of over \$6 billion from more than 26,000 Medicaid participating providers.

With HP as a prime, the EOHHS engaged the HP-CGI Team to embark on a major initiative to build a state-of-the-art Medicaid Management Information System (“NewMMIS”) to replace an existing mainframe application. HP selected CGI as its partner given our best practices approach to full software system lifecycle development and our application of rigorous quality processes.

Primary Relevance to Iowa

- ▶ Demonstrates CGI's comprehensive knowledge of Medicaid business rules, claims data and processing.
- ▶ Highlights that CGI has an excellent reputation amongst our partners and competitors for leveraging best practice methodologies and applying rigorous quality processes.

Commonwealth of Virginia – Health Information Exchange Operational and Strategic Planning

In 2010 CGI consulted with the Virginia Office of Health Information Technology to develop Virginia’s statewide Health Information Exchange (HIE) Strategic and Operational Plans. In this role, CGI worked with the Virginia Department of Health and affiliated workgroups and commissions in the development of the Commonwealth’s Strategic & Operational Plans for Health Information Exchange. Also in 2010, CGI assisted the Virginia Department of Health in the creation of a Request for Proposals (RFP) for an existing non-profit corporation to become the Governance Body for the Commonwealth of Virginia’s Health Information Exchange (COV-HIE). In this role, CGI assisted in the writing and creation of the RFP, coordinated activities associated with the governance requirements and HITAC workgroups and commission meetings.

Primary Relevance to Iowa

- ▶ Demonstrates CGI’s first hand understanding of Health Information Exchanges which will inform future stages of the EHR Incentive Program



Housing and Urban Development Contract Management and Consulting

CGI pays over \$1.5B annually in federal subsidies on behalf of our clients. We are the recognized private partner leader within the industry, administering over 2,900 contracts and 240,000 housing units across the country.

Through consulting, technology and outsourcing services, CGI combines our 15 years of hands-on experience with deep housing process and technology expertise to help agencies access additional funding and improve the quality of service delivery. In fact, CGI contracts with the Ohio Assisted Housing Services Corporation to provide housing and urban development contract management and consulting employing 55 Ohio-based employees. Our proven track record has led to CGI becoming the largest U.S. housing contract administrator and one of the leading public housing management and consulting companies. CGI provides the following key service and solutions:

- ▶ Full-service contract administration for such activities as administering multifamily housing contracts, calculating rental subsidies and enforcing owner obligations. CGI pays over \$1.5 billion annually in federal subsidies on behalf of our clients. We are the recognized private partner leader within the industry, administering over 2,900 contracts and 240,000 housing units across the country. Our proprietary systems have been recognized by federal, state and local agencies as a key tool in achieving superior performance and fee recognition in the performance-based contract administration environment.
- ▶ Program management and consulting services have helped public housing agencies operate more efficiently and attain the highest level of HUD-rated performance. Services include direct management of programs, performance assessments and change management, and the implementation of processes and tools that allow for the delivery of superior customer service for landlords, owners and tenants and the achievement of the highest levels of compliance with HUD regulations
- ▶ Full-service technology services have given Performance Based Contract Administrations (PBCAs) and public housing authorities the ability to enhance their current technology platforms and to lower staffing costs. Our managed technology services include systems acquisition, maintenance and support; network management; end-user help desk; data processing; off-site data storage and systems management; disaster recovery; SAS-70 certified data center operations; and application development and service provisioning.

Primary Relevance to Iowa

- ▶ Attests to our ability to successfully design, build and operationalize an end-to-end business service including multi-stakeholder program management, communications planning, call center, business process design, procedure and policy management, infrastructure management, and disaster recovery.
- ▶ Demonstrates our skill at operationalizing a federal program that is managed locally.
- ▶ Reflects our commitment to continuous quality improvement.



Shown in Exhibit 5-8, CGI counts the following clients under our Housing Contract Management and Consulting:

Exhibit 5-8: Sample List of CGI’s Housing Contract Management Customers

Sample List of Housing Contract Management and Consulting Customers	
Assisted Housing Services Corporation - Ohio	St. Mary Development Corporation
Assisted Housing Services Corporation - DC	Tampa Housing Authority
California Affordable Housing Initiatives	Tennessee Housing Development Agency
North Tampa Housing Development Corporation	Volunteers of America
New York State Housing Trust Fund Corporation	ArcelorMittal Mines Canada
Akron Metropolitan Housing Authority	Emphasys
Cuyahoga Metropolitan Housing Authority	Lorain Housing Authority
Housing Authority of the City of Pittsburgh	Port Arthur Housing Authority
Lake Metropolitan Housing Authority	Nowalk Housing Authority
Midwest Affordable Housing Management Association	Oakland Housing Authority



State of Louisiana Road Home

The Road Home Program was established in 2006 in the wake of Hurricanes Katrina and Rita to provide financial assistance to property owners. It is the largest single housing recovery program in U.S. history. CGI delivers full IT operations and service management to support Louisiana's Road Home Program. The CGI team is currently delivering application maintenance, user service desk and desktop support, business intelligence and data analytics reporting, IT security, and disaster recovery and continuity of operations planning.

Louisiana benefits from CGI's more mature model of IT service provisioning, delivered using industry-standard practices, measured with service level agreements, and supported by commercially oriented pricing.

A complete transition of service providers was accomplished from March to June 2009 and fully accepted by the State. To assist the State with more aggressive transition, the CGI team formally took over operations in mid-April, well before the contractual transition completion date. The transition has been virtually seamless with no interruption of service and no negative exposure to public comment, which was a chronic problem for the previous service provider's operations. The State and its stakeholders now benefits from greater visibility into both projects and operations through the process discipline that is part of the new operating model. Because there is more control over requests for work and appropriate authorization to do work, the State can make better

Primary Relevance to Iowa

- ▶ Experience in managing and operating a program-based call center for a high visibility program
- ▶ Skilled at implementing a disciplined program management methodology
- ▶ Excellent track record of providing comprehensive application and infrastructure management; hosting, transparency to the public on payment of funds; data reporting to state and federal officials.
- ▶ A mission critical health and human services program.

informed choices among investments to enhance the program applications and operations. From a program perspective, state staff members have greater visibility into program business results as they can work directly with CGI's reporting team to get access to program data. This streamlined process supports the State in analyzing and cross-checking program activities, offering a level of independence that helps support strong program oversight and better outcomes.

In short, Louisiana benefits from CGI's more mature model of IT and BPO service provisioning, delivered using industry-standard practices, measured with service level agreements, and supported by commercially oriented pricing. With CGI, they found a flexible and dedicated partner with a real commitment to creating a genuine, meaningful partnership with the State and the new Road Home Program operations providers.

Relevance to Medicaid Provider Incentive Program

CGI has consolidated our relevant past performance experience and demonstrated how it applies to the design, build and operation of Iowa as indicated in Exhibit 5-9.



Exhibit 5-9: Relevant CGI Experience for Iowa

	Relevant Attributes							Relevant Subject Matter							Relevant Technical Components		
	Relevance to Virginia EPIP	Customer Expectations Met or Exceeded	High Visibility Project	Short Timeframe to Implement	Adhered to Federal State Regulations	Managed to Service Level Agreements	Health Information Technology Related	Project Management	Communications Management	Policy and Procedure Management	Call Center and Dispute Resolution	Quality/Data Reporting	Audit and Fraud/Waste/Duplication Monitoring	Eligibility Determination and/or Payment Management	Infrastructure Management & Hosting	Portal Development and Management	Interface Development and Management
Texas Medicaid Incentive360	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ohio MPIP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
NLR Registration and Attestation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓	
NPPES	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓			✓	
PECOS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓			✓	
Medicare Appeals System	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓			✓	
CMS Websites	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓			✓	✓	
Medicare RAC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓		✓	
PQRI	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓				✓	
Federal Reporting.gov	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓			✓	✓	✓	
CO Medicaid Portal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓			✓	✓	
PA Medicaid Audit	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	
California MMIS	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓				✓	
Massachusetts MMIS	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓				✓	
Virginia HIE Planning	✓	✓	✓	✓	✓		✓	✓	✓	✓							
Housing Contract Management and Consulting	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓	
Louisiana Road Home	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	✓	✓	

5.4 LETTERS OF REFERENCE

Letters of reference from three (3) previous clients knowledgeable of the bidder's performance in providing services similar to those sought in this RFP, including a contact person, telephone number, and electronic mail address for each reference. It is preferred that letters of reference are provided for services that were procured in a competitive environment.

Iowa will get the best insight into our Medicaid Incentive360 offering or our company through references from all of our EHR Incentive multi-state solution participant states. Our state partners are very willing to provide a reference if Iowa initiates the request through a phone call or email. Unfortunately, all of our participant state references are subject to strict department regulations that forbid them from pro-actively writing Letters of Reference for their contractors. Please see their contact information in Section 5.2 Similar Services.

As a supplement, CGI has provided 3 Letters of Reference from other satisfied CGI customers at the end of this Tab.

5.5 SUBCONTRACTOR MANAGEMENT

• Description of experience managing subcontractors, if the bidder proposes to use subcontractors.

CGI does not intend to use subcontractors to deliver the services contained in this RFP response.

5.6 PERSONNEL

5.6.1 TABLES OF ORGANIZATION

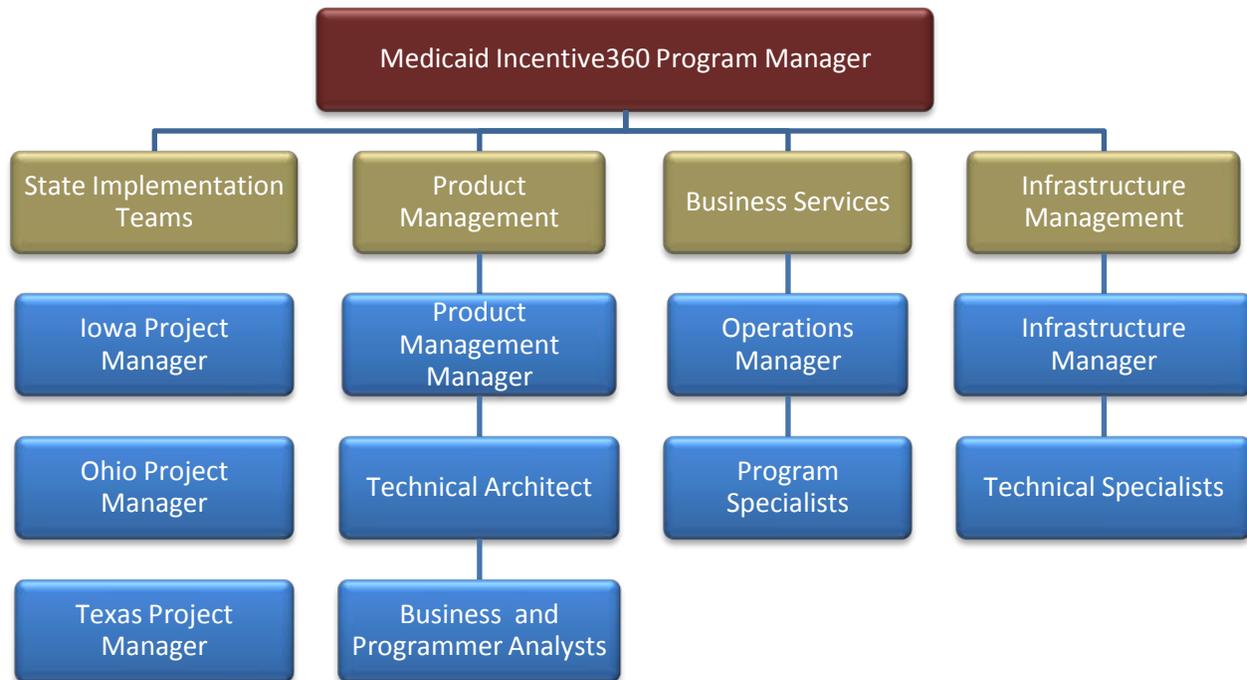
Illustrate the lines of authority in two tables:

One showing overall operations

CGI is recognized as an industry leader for our ability to execute complex projects that are on time, on budget and on schedule. Much of our success can be attributed to formulating the right team with the appropriate mix of skills for each of our engagements. The Medicaid Incentive360 multi-state program features a structure with clear lines of delineation of authority so that everyone on the team is positioned for success. Furthermore, it is designed to realize economies of scale through pooled experience which leads to greater efficiencies and reduced costs for our participant states.

Exhibit 5-10 features our Medicaid Incentive360 multi-state program team organizational structure and demonstrates the relationship to the Iowa EHR Medicaid Incentive Program.

Exhibit 5-10: Medicaid Incentive360 Multi-State Organization Chart



One showing staff who will provide services under the RFP

CGI has assembled a highly skilled and technically competent team to implement and support the Iowa EHR Provider Incentive Program. Given the short timeframe to implement, CGI has assigned many of our Medicaid Incentive360 experts to the Iowa team as exemplified by our proposed staff. Each of these candidates has been heavily involved with the program since its inception. The proposed staff for the Iowa EHR Medicaid Incentive Program Administrative Tool Project is as follows:

- ▶ **Jennifer Salas, Engagement Manager.** As a Director of Consulting, Ms. Salas is the Medicaid Incentive360 Engagement Manager. Her background is in delivery specializing in account, program, and project management, process engineering, quality management, and change management. Ms. Salas is PMP certified and excels in leadership, delivery, organization and management. Backed with the knowledge of industry best practices, Ms. Salas has the know-how to foster productive client relationships, synergize teams, and has the proven ability to drive tasks to completion. With a solid background in Information Systems, hands-on software development experience, and a Masters in Information Technology from Northwestern University, Ms. Salas has led several teams in the delivery of complex, high visibility projects for CGI with a focus on public sector applications.



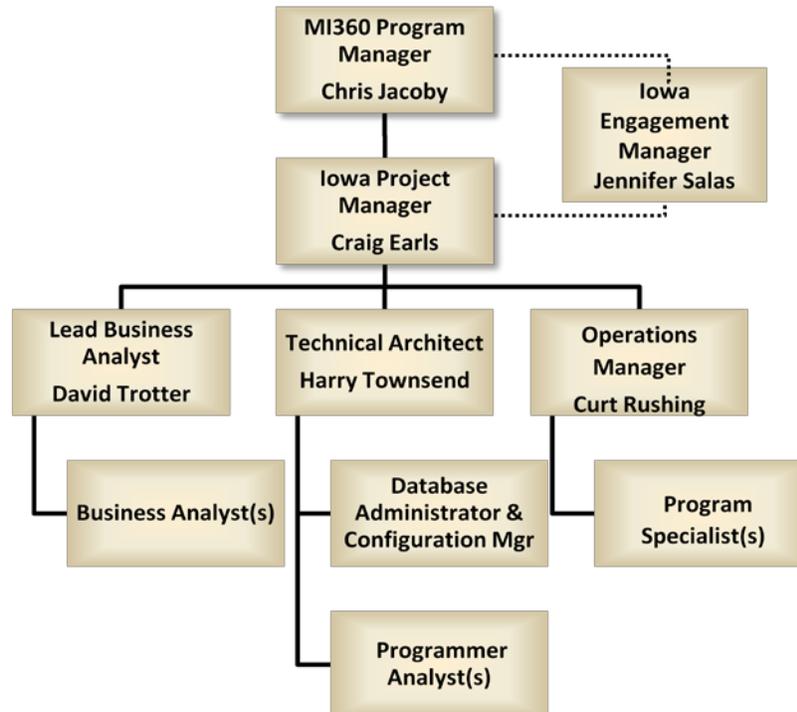
- ▶ **Chris Jacoby, Medicaid Incentive360 Program Manager.** As a Director of Consulting Services, Mr. Jacoby is an Information Technology professional with more than 25 years of professional experience ranging from Software Developer to Portfolio Manager. Leveraging his software development skills, portfolio management and project management skills and knowledge, Mr. Jacoby provided leadership and oversight required to complete development, testing, and deployment of Medicaid Incentive360 baseline solution for the State of Texas as well as the successful implementation and operations for Ohio. His extensive Project Management experience on large, complex ERP and systems integration projects provides the necessary skills for managing and maintain a multi state Medicaid Incentive Payment EHR product. He is currently the Medicaid Incentive360 Program Manager with oversight for the build and delivery of the Medicaid Incentive360 baseline solution with state-specific configurations.
- ▶ **Craig Earls, Iowa Project Manager.** With more than 13 years in the Information Technology industry, Mr. Earls is a pivotal resource to the Medicaid Incentive360 program. Most recently, Mr. Earls lead key components of the Ohio Medicaid Provider Incentive Program implementation and managed all aspects of the cutover to going live. Mr. Earls has a wide range of leadership experience including project management, resource estimation and planning, software test planning and execution, functional and technical requirements analysis, training development and delivery. He has led the design, development, and implementation of numerous information systems, and is knowledgeable in wide range of information technologies, including client/server architecture, application prototyping, and software testing methodologies. Mr. Earls also has extensive experience in the management of medium to large teams. As the Medicaid Incentive360 program lead Subject Matter Expert, Mr. Earls possesses a comprehensive understanding of the Federal Rules and Regulations for the EHR Incentive Payment program in order to define the requirement specifications for the Medicaid Incentive360 solution. Throughout design, development, testing, and implementation, Mr. Earls reviews the Medicaid Incentive360 baseline solution to ensure compliance with functional and technical design requirements. Mr. Earls' knowledge about the Medicaid Incentive360 program along with his leadership, management, client relations and business analyst skills are the necessary attributes for managing the configuration and deployment of the baseline solution.
- ▶ **Harry Townsend, Technical Architect.** After 29 years in the Information Technology industry, Mr. Townsend has acquired a vast repertoire of knowledge and experience with developing the technical architecture for a wide range of business solutions for the state and local government and the private sector. He is creative in his approach to understanding the business problem before applying technology to develop the client's solution. His understanding and application of current technology to develop functional and technical solutions is unsurpassed. As the Technical Architect for Medicaid Incentive360, Mr. Townsend has a deep understanding of the Federal Rules and Regulations in order to understand requirement specifications for the Medicaid Incentive360 baseline solution design. His understanding of the Medicaid Incentive360 design enables him to design, configure, and code the framework for the baseline solution. Mr. Townsend is one of CGI's lead technical architects. In addition to the Medicaid Incentive360 baseline solution, Mr. Townsend has developed technical solutions for Child Welfare Case Management, ERP Financial, and Tax systems for state and local governments.



- ▶ **Curtis Rushing, Operations Manager.** As the Medicaid Incentive360 Operations Manager, Mr. Rushing manages the business services team which provides operational support to Medicaid Incentive360 participant states. With over 15 years of IT experience, Mr. Rushing is an experienced consultant in public sector healthcare, specifically Medicaid claim process. His experience includes analyzing business requirements, managing project teams, analyzing call center statistics, documenting procedures, developing quality monitoring processes, and testing system software. With extensive experience with managing personnel, Mr. Rushing's skills include workforce planning, hiring, training, performance counseling, compensation planning, and motivating team members. In addition, Mr. Rushing is experienced in developing training materials, process control manuals, and procedures manuals. He has led teams that delivered service for government clients such as the Department of Education, Department of Commerce, Bureau of the Census, and the Alabama Medicaid Agency.
- ▶ **David Trotter, Lead Business Analyst.** With more than 20 years in the Information Technology industry, Mr. Trotter is a key subject matter expert for the Medicaid Incentive360 program. Mr. Trotter is a Certified Software Test Engineer (CSTE), and has a proven record across a wide spectrum of applications. Mr. Trotter possesses a comprehensive understanding of the Federal Rules and Regulations for the EHR Incentive Payment program. Throughout design, development, testing, and implementation, Mr. Trotter reviewed and tested the Medicaid Incentive360 baseline solution to ensure compliance with functional and technical design requirements. Mr. Trotter has program and project management, system specification, software development, system and integration testing, system delivery, and end-user training experience. His program management and software development skills have been applied in the public and private section client's such as aerospace industry. His testing & system integration skills have been applied in the Medicaid, telecommunications and insurance industries. He always endeavors to deliver project deliverables on schedule, on budget.

Exhibit 5-11 shows the project team who will be working with Iowa on the initial implementation and will continue to support Iowa throughout the 10 year term.

Exhibit 5-11: Iowa Project Team



5.6.2 NAMES AND CREDENTIALS OF PERSONNEL – KEY CORPORATE PERSONNEL

Include the names and credentials of the owners and executives of your organization and, if applicable, their roles on this project.

Name	Office Held
ANDERSON, R. David	Executive Vice-President and Chief Financial Officer
DUBÉ, Benoit	Vice-President, Corporate Legal Affairs and Corporate Secretary
FIGINI, Joseph C.	Senior Vice-President, US General Counsel & Assistant Corporate Secretary
HANNUM, Robert D. Jr.	Senior Vice-President U.S. Northeast
IHRIG, Peter G.	Senior Vice-President , U.S. Central and South
MASSE, David G.	Corporate Secretary
MOREA, Donna S.	President, U.S., Europe and Asia
ROACH, Michael E.	Chief Executive Officer
ROY, Jacques	Senior Vice-President , Finance and Treasury
TURNER, Nazzic S.	Senior Vice President and General Manager



Name	Office Held
WAPLE, Michael	Director and Controller -United States

Include names of the current board of directors, or names of all partners, as it applies.

The Board of Directors for CGI Group Inc., the ultimate parent company for CGI Technologies and Solutions Inc., is shown in Exhibit 5-12:

Exhibit 5-12: CGI’s Board of Directors

Name	Affiliation
BOIVIN, Claude	Director of Companies
BOURIGEAUD, Bernard	Director of Companies
BRASSARD, Jean	Director of Companies
CHEVRIER, Robert	President, Roche Management Co. Inc.
D’ALESSANDRO, Dominic	Director of Companies
d’AQUINO, Thomas P.	Chairman and Chief Executive Intercounsel Ltd. and Senior Counsel and Chair of the Business Strategy and Public Policy Group Growling Lafleur Henderson LLP
DORÉ, Paule	Director of Companies
EVANS, Richard B.	Chairman of the Board, AbitibiBowater
GODIN, Serge	Founder and Executive Chairman of the Board
IMBEAU, André	Founder and Executive Vice-Chairman of the Board and Corporate Secretary
LABBÉ, Gilles	President and Chief Executive Officer, and a director He’roux-Devtek Inc.
MERCIER, Eileen A.	Director of Companies
ROACH, Michael E.	President and Chief Executive Officer

Include resumes for all key corporate, administrative, and supervisory personnel who will be involved in providing the services sought by this RFP. The resumes shall include: name, education, and years of experience and employment history, particularly as it relates to the scope of services specified herein. Resumes shall not include social security numbers.

CGI has included resumes for all key project members at the end of this tab.



5.6.3 PROJECT MANAGER AND KEY PROJECT PERSONNEL

Include names and credentials for the project manager and any additional key project personnel who will be involved in providing services sought by this RFP. Include resumes for these personnel. The resumes shall include: name, education, and years of experience and employment history, particularly as it relates to the scope of services specified herein. Resumes should not include social security numbers.

Include the project manager's experience managing subcontractor staff if the bidder proposes to use subcontractors.

The core team of CGI program experts who conceived, designed and developed CGI's solution and services continues to spearhead CGI's national Medicaid Incentive360 program. As a testament of our commitment to making Iowa's EHR Incentive Program successful, we are proposing a lead staff of Medicaid Incentive360 experts, all of whom have been a part of the program since its inception. Their direct knowledge and expertise of the solution and broader program will be a significant advantage to helping Iowa achieve its project's objectives, goals, and schedule. Exhibit 5-13 highlights proposed lead staff for Iowa's EHR Incentive Program as well as their involvement with past state implementations.

Exhibit 5-13: Proposed Lead Staff for Minnesota's EHR Incentive Program

Name	Proposed Role for Minnesota EHR Incentive Program	Founding Member of Medicaid Incentive360 Program Team	EHR Incentive Program Subject Matter Expert	Involvement in Ohio Medicaid Provider Incentive Program	Involvement in Texas Medicaid Incentive360
Jennifer Salas	Engagement Manager	Yes	Yes	Engagement Manager Communications Manager	Proposal Manager
Chris Jacoby	Medicaid Incentive360 Program Manager	Yes	Yes	Medicaid Incentive360 Program Manager	Medicaid Incentive360 Program Manager
Craig Earls	Project Manager	Yes	Yes	Implementation Project Manager Functional Lead	Functional Lead
Harry Townsend	Technical Architect	Yes	Yes	Technical Architect	Technical Architect
Curtis Rushing	Operations Manager	Yes	Yes	Operations Manager	Operations Manager
David Trotter	Lead Business Analyst	Yes	Yes	Business Analyst	Business Analyst

CGI has included resumes for all key project members at the end of this Tab.

5.7 FINANCIAL STATEMENTS

The bidder shall submit audited financial statements from independent auditors for the last three (3) years. Entities not required to have audited financial statements may submit CPA-prepared unaudited financial statements.

CGI is focused on the essentials of running a sound and stable business for the long term. Our 35 years of long-term growth is a result of CGI's business model and emphasis on growing our backlog of committed orders. Today, at \$13.6B, our profitable backlog provides revenue and profit visibility for our stakeholders and allows our clients continued confidence in our stability as their IT services provider.

Recent economic events have underscored the need to focus on the fundamentals — delivering projects on time and on budget, generating cash, managing costs, maintaining our low debt structure and channeling business development efforts to achieve our profitable growth strategy. CGI's discipline in adhering to these fundamentals has allowed us to maintain industry-leading profitability through challenging times. Most importantly, we have continuously grown over the last 35 years.

During difficult economic times, it is especially important for clients to feel confident that their services will be uninterrupted by the organizational shifts and financial instability of their vendors. CGI's 35 year record and current state of financial strength, provides an excellent foundation upon which to continue to provide dependable, high quality operations and maintenance services to Minnesota for the years ahead.

CGI has provided our financial statements for the past three years at the end of this Tab. CGI's annual reports can be viewed in their entirety at <http://www.cgi.com>.

5.8 TERMINATION, LITIGATION, AND INVESTIGATION

Bid Proposals must indicate whether any of the following conditions have been applicable to the bidder, or a holding company, parent company, subsidiary, or intermediary company of the bidder during the past five (5) years. If any of the following conditions are applicable, then the bidder shall state the details of the occurrence. If none of these conditions is applicable to the bidder, the bidder shall so indicate.

- List any contract for services that the bidder has had that was terminated for convenience, non-performance, non-allocation of funds, or any other reason for which termination occurred before completion of all obligations under the contract provisions.

CGI and its parent company and affiliates (collectively for the purpose of this response the "CGI Companies") have successfully completed contracts for customers throughout its 35-year history. Currently, the CGI Companies have more than \$4.5 billion in annual revenues and 31,000 employees in dozens of countries across the globe. With respect to State and local government projects we have not had a State contract terminated for cause in the past 5 years. We do not track terminations for convenience, but we know that customers have occasionally decided to terminate a contract before all work could be completed. This has occurred for various reasons, such as: unexpected fiscal constraints, changes or reorganizations in a customer's management or business objectives, customer decisions to complete projects with internal resources, or termination of prime contracts for which the CGI Companies were performing as a subcontractor. No actual or initiated terminations of the CGI Companies' contracts could hinder CGI's work on the proposed project. CGI is proud that in its long history it has never been barred from performing services for a government agency.



- List any occurrences where the bidder has either been subject to default or has received notice of default or failure to perform on a contract. Provide full details related to the default or notice of default including the other party's name, address, and telephone number.

As described above we have not had a State contract terminated for cause in the past 5 years. We do not track notices of default.

- List any damages, penalties, disincentives assessed, or payments withheld, or anything of value traded or given up by the bidder under any of its existing or past contracts as it relates to services performed that are similar to the services contemplated by this RFP. Include the estimated cost of that incident to the bidder with the details of the occurrence.

Within the past five (5) years, the CGI Companies have not had any damages, penalties, disincentives assessed, or payments withheld, or anything of value traded or given up under any of its Medicaid Incentive360 contracts.

- List and summarize pending or threatened litigation, administrative or regulatory proceedings, or similar matters related to the subject matter of the services sought in this RFP.

Within the past five (5) years, the CGI Companies have not had any pending or threatened litigation, administrative or regulatory proceedings, or similar matters related to any of its Medicaid Incentive360 contracts.

- List any irregularities that have been discovered in any of the accounts maintained by the bidder on behalf of others. Describe the circumstances of irregularities or variances and detail how the issues were resolved.

CGI has interpreted “accounts” as State Provider accounts that register, attest and use our Medicaid Incentive360 portals. There have been no irregularities or variances in our Provider accounts that we maintain on behalf of our Medicaid Incentive360 participant States.

- List any details of whether the bidder or any owners, officers, primary partners, staff providing services or any owners, officers, primary partners, or staff providing services of any subcontractor who may be involved with providing the services sought in this RFP, have ever had a founded child or dependent adult abuse report, or been convicted of a felony.

Note: Failure to disclose information about the matters in this section may result in rejection of the Bid Proposal or in termination of any subsequent contract. This is a continuing disclosure requirement. Any such matter commencing after submission of a Bid Proposal, and with respect to the successful bidder after the execution of a contract, shall be disclosed in a timely manner in a written statement to the Agency. For purposes of this subsection, timely means within thirty (30) days from the date of conviction, regardless of appeal rights.

CGI and its subcontractors will not knowingly assign personnel to provide services sought through the RFP who have had a founded child or dependent adult abuse report or been convicted of a felony.



LETTERS OF RECOMMENDATION



RESUMES



FINANCIAL STATEMENTS